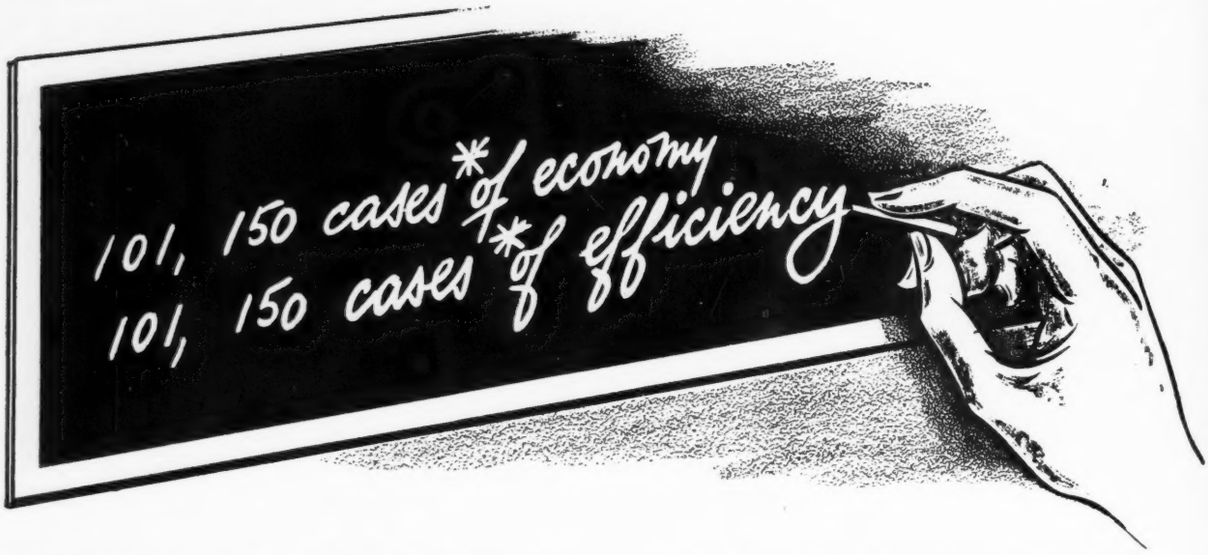
the MODERN HOSPITAL

VOLUME 57 NOVEMBER 1941 NUMBER 5

A Blackboard Demonstration of an unusual Service to Hospitals



WECK SERVICE to hospitals is summarized in a sentence on the blackboard above...

101,150 cases of efficiency

101,150 cases of economy

And these 101,150 cases* cover a wide and varied service to hospitals from coast to coast: NEW INSTRUMENTS made in the Weck plant by Weck's experienced craftsmen . . . Weck-repaired and Weck-reconditioned instruments saving hospitals thousands of dollars annually . . . ranging all the way from the replacement of a broken screw, to the sharpening anew of the dulled microtome knife blade . . . but so EFFICIENTLY IS THIS DONE that Weck is able to GUARANTEE *one-week return of all repairs.*

In this drive for ECONOMY Weck has never lowered EFFICIENCY. For Weck pioneered the way with CRODON, The Chrome Plate of QUALITY. . . now Weck also offers STAINLESS STEEL where your surgeons prefer that finish.

The 101,150 cases* prove the wide acceptance of the Weck ECONOMY with EFFICIENCY idea in serving hospitals. For now hospitals in the 48 states order by mail, if they wish, from Weck with perfect CONFIDENCE that whatever their "case" or "problem" it will be solved in the EFFICIENT and ECONOMICAL manner by Weck. Fifty years plus of Weck service is final criterion of this claim.

Therefore, whether it is NEW instruments, or the repair *and return in one-week,* of old; whether it is rubber tubing, or gloves, or sheeting; or a host of other hospital supplies, *check with Weck* for ECONOMY and EFFICIENCY *in every case.*

*By "cases" here we refer to the entered numbered orders in the Weck files. One order may cover few or many hundreds of dollars, and a large or small variety of items. It would reach an almost fantastic figure if we tried to use the total number of "items" sold the Weck-way since its founding over fifty years ago.

Founded 1890

Edward Weck & Co., Inc.

Manufacturers Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street Brooklyn, N.Y.

CONTENTS

For November 1941

Just in Passing—

NO ONE has given (in print) adequate attention to that important person in hospital life, the administrator's wife. Next month this great omission will be rectified. Women administrators and men who are unmarried can skip the article, but they probably won't.

WHAT happens to the professional services of a hospital under the inclusive rate plan? Are these services greatly abused and hospital costs thereby unduly and undesirably increased? We need to know. A study of electrocardiography under inclusive rates gives us a detailed and carefully prepared answer. The study was made by two physicians at New Haven Hospital. It will appear next month.

SHOULD we employ professionals in raising funds? This forms the subject of an informal debate next month.

EVERYONE wants to know how to organize refresher courses for graduate nurses. The answer will be given in the December issue.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
.....	.....	.....
.....	.....	.....

Return to .....

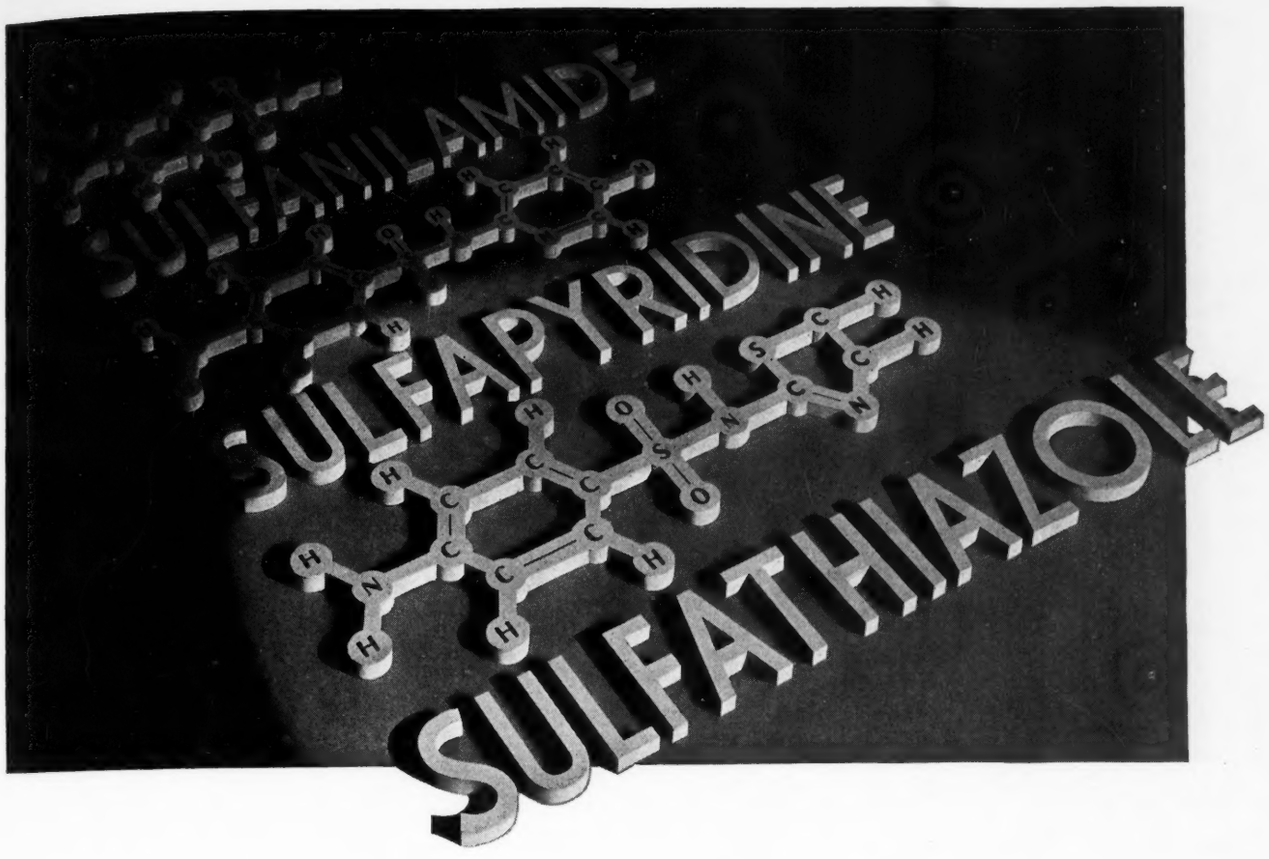
The Modern Hospital

OTHO F. BALL, M.D., *President*
RAYMOND P. SLOAN, *Editor;* ALDEN B. MILLS, *Managing Editor*
MILDRED WHITCOMB, *Associate Managing Editor*

EDITORIAL BOARD

EDITORIAL CONSULTANTS

Published monthly and copyrighted, 1941, by The Modern Hospital Publishing Company, Inc., 919 N. Michigan, Chicago. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; J. G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A.



Sulfathiazole, Lilly

SINCE the introduction of sulfanilamide in 1937, studies of this and related drugs have continued without interruption. Out of this investigation has come sulfathiazole, which seems to have certain advantages over other sulfonamides.

Sulfathiazole, in comparison with sulfapyridine, seems to have more uniform absorption, less conjugation of the drug after absorption, less tendency to provoke nausea and vomiting, and greater effectiveness against the staphylococcus. A popular form of administration is 'Enseals' (Enteric-Sealed Tablets, Lilly) Sulfathiazole, 0.325 Gm. (5 grains) which are supplied in bottles of 100, 500, and 1,000.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

Doctors' Group Helps

• When it becomes known how helpful a professional advisory committee can be in solving certain hospital problems other institutions no doubt will follow the example of Albany Hospital, Albany, N. Y. Its professional advisory committee is just that—a group of five of the staff, with the director, medical director and head of the nursing department serving ex officio, whose function it is to make suggestions concerning any professional department of the hospital that will lead to better patient care, economy or other improvement. Also, when the administration wants some professional problem investigated, it refers to the committee for study and recommendation.

Everett Jones, director, cites an example. Recently, a complete study of sterilizing methods from the professional standpoint was wanted. This group, working with the department of bacteriology of the Albany Medical College, got busy and made numerous recommendations that the administration was glad to adopt.

Another important service it has rendered recently is working with the pharmacy department on a study of various antiseptic solutions used throughout the hospital in an endeavor to make substitutions that would save money. One result has been the substitution of tincture of zephiran for tincture of merthiolate.

"One of the most valuable groups from the standpoint of helping us do a better job," is the way Mr. Jones puts it.

A Business Tip

• Over the teacups in the attractive shop she conducts for Hospital of St. Barnabas and for Women and Children, Newark, N. J., Mrs. Eliza H. Walmsley was discussing merchandising methods. Despite the heat of a midsummer's afternoon, the subject of Christmas business presented itself. "Carefully selected gifts, priced right and effectively displayed will move," she insists. "If they don't, the chances are something is wrong with the way they are exhibited. The customer must never get used to seeing the same things in the same places."

The particular item on which the buyer has his heart set may not be stocked. Very well, get it for him. Give him a chance to examine it. This is precisely what Mrs. Walmsley does, conducting what amounts to a personal shopping service for frantic doctors and other hospital people who can't take the time to visit the stores. Not only does she get it for them, but she writes out the cards and wraps the gifts, identifying them plainly so that Aunt Carrie's flannel bed jacket doesn't go to the wife instead of the frilly negligee ordered for her.

"Such personalized service is a sure panacea for any Christmas slump. Try it."

To Our Patients

• Another little booklet dedicated "To Our Patients" bears the name of the South Baltimore General Hospital, Baltimore. It starts with the usual friendly note of greeting, signed by E. Reid Caddy, director, and after a brief account of the history of the institution quotes a generous passage from "Doctor Hudson's Secret Journal" by Lloyd C. Douglas. It would be interesting to know how many hospital people have read this book. Those who haven't would do well to order a copy from the library without fail; those who have should read it again.

Because we hear hospitals compared so frequently with hotels your Roving Reporter is going to quote just one small paragraph: "This is not a hotel. Hotels must pay their own way or close up. Hospitals do not pay their way, but they do not close up; for, at the end of the year, the deficit is absorbed by a company of kind-hearted people who believe that we are trying to do our best. We hope you will share in this belief; for it is important to your comfort—and, perhaps, also to the promptness of your recovery—if you will consider this place as a friendly refuge, not a mere money-making repair shop."

A happy idea to include this explanation of hospital service along with other information of interest to patients. Congratulations, Mr. Caddy!

The Whole Story

• Through the thoughtfulness of George P. Bugbee, superintendent of Cleveland City Hospital, we had a chance to read the other day a little article in the *Cleveland Plain Dealer* that, although not written for hospitals, has a definite hospital application. In a question and answer column of that paper appeared an inquiry from a domestic employe regarding how she should budget her income of $7 per week "plus board, room and washing."

In answer the columnist stated:

"Actually you are earning quite a nice salary in spite of the fact that it doesn't sound so impressive to say that your money income is $7 a week. If you were paying for board and room, you would expect to pay not less than $30 a month. So, at minimum, you are earning $60.35 per month. When you add to this fact the money advantage of not having to buy lunches or pay transportation, you add at least $13.50. This makes your income equal in buying power to a money income of not less than $73.85 per month.

"We take it for granted that you are doing domestic service and point out these facts about your income because so many girls doing the same type of work underestimate the income they receive and overestimate the buying power of money incomes earned in other lines of work."

Cutting Personnel Turnover

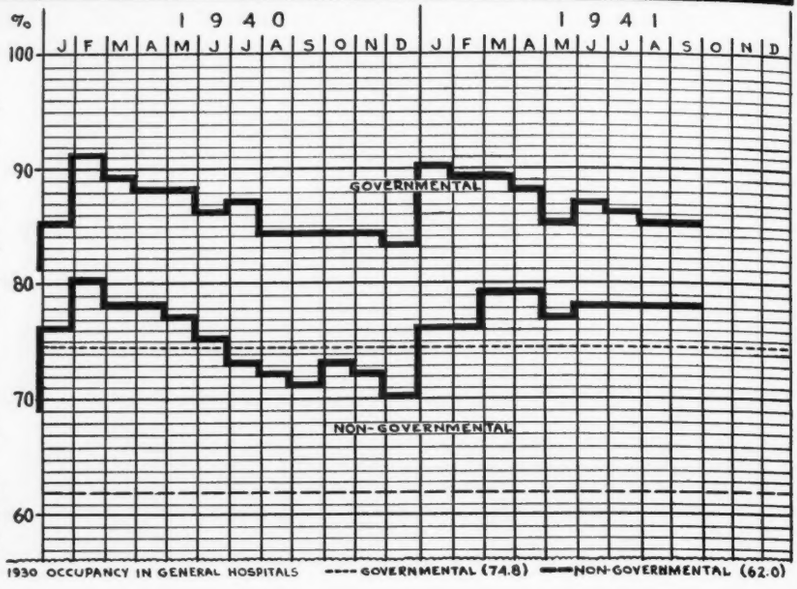
• One of the members of our editorial board who has been particularly interested in personnel management has been pondering the question of turnover. He knows that it is expensive to have a high turnover of personnel and that it dilutes the quality of service. The department head has the most influence on employe relations. So this administrator adopted the following procedure to reduce turnover.

Each month the total number of employes who have left the service of the hospital is tabulated by departments. Each department head is then notified by written memorandum how many separations there were from the entire service of the hospital during the month and how many were charged against his or her department. By comparing the figures for their department with figures for the entire hospital, the department heads become more conscious of their labor turnover and make increased efforts to reduce it. If the percentage is large, they are stimulated to use better methods of selection in order to lower the turnover. It has also been noted that the department heads are now giving explanations for each termination.

HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1941: Sept.	1941: Aug.	1940: Sept.	1940: Aug.
Governmental:						
New York City	17	10,380	91*	91	94	96
New Jersey	5	2,136	90*	90*	85	82
N. and S. Carolina	20	2,655	76*	76	72	73
New Orleans	2	2,800	77*	77*	84	83
San Francisco	3	2,255	107*	107	101	98
St. Paul	1	850	67*	65	65	67
Chicago	2	3,500	85*	85*	88	89
Total[4]	50	24,576	85*	85*	84	84
Nongovernmental:						
New York City[3]	70	16,526	77*	77*	69	66
New Jersey	56	8,111	76*	76*	71	68
N. & S. Carolina	109	7,913	67*	68	66	67
New Orleans	6	1,233	84	87	75	82
San Francisco	16	3,178	81*	81	76	74
St. Paul	9	1,134	80*	78	69	72
Chicago	28	5,870	73*	73*	67	67
Cleveland	15	3,085	85*	78	78	81
Total[4]	309	47,050	78*	78*	71	72

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



September Occupancy Maintains High Level; Construction Also Up

Occupancy in nongovernmental general hospitals stayed at 78 per cent during September, according to the preliminary reports available at time of going to press. This is a marked advance over the 71 per cent reported for September 1940 and the 68 per cent of September 1939. While occupancy in September dropped slightly from the August levels in the Carolinas, New Orleans and St. Paul, it was up dramatically in Cleveland.

In the governmental general hospitals occupancy stayed at 85, a level that has shown little change since May. Last year the occupancy in these hospitals was 84 per cent in September and for the year previous it was at the present level, 85 per cent.

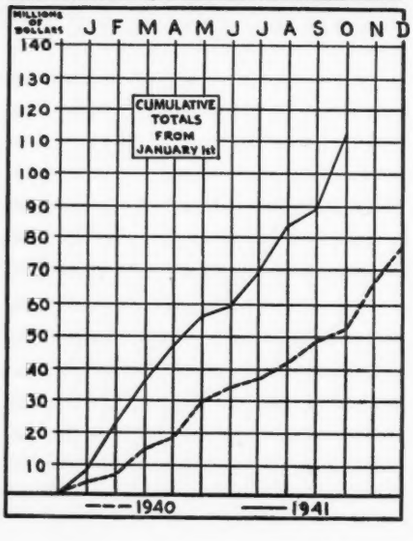
It is apparent that the large increase in the occupancy of the voluntary hospitals has been made without any corresponding reduction in the load (often an overload) in the governmental institutions. For the first nine months of this year the average occupancy in the nongovernmental hospitals was 78 per cent, compared with 76 per cent last year and 72 per cent the year before. In governmental hospitals the figure was 87 per cent for all three years. These mounting figures on average occupancy of voluntary hospitals tell only part of the story, since the bed capacity is also rising.

Commodity Price Comparisons

Commodity	Sept. 12	Oct. 18
General Wholesale Prices	95.8	95.8
Grain	88.1	80.9
Food	92.1	91.3
Textiles	96.8	95.7
Fuel	96.7	97.5
Building Materials	117.3	124.4
Drugs, Fine Chemicals	222.9	222.9

New hospital construction projects hit a high mark in the period from September 8 to October 20 with a total of 101 projects of which 98 reported costs of $23,340,198. This brings the total hospital construction authorized since the first of January to $112,231,171 compared with a total on the same date last year of $51,638,000. Thus far this year the new construction has more than doubled last year's hospital construction.

HOSPITAL CONSTRUCTION

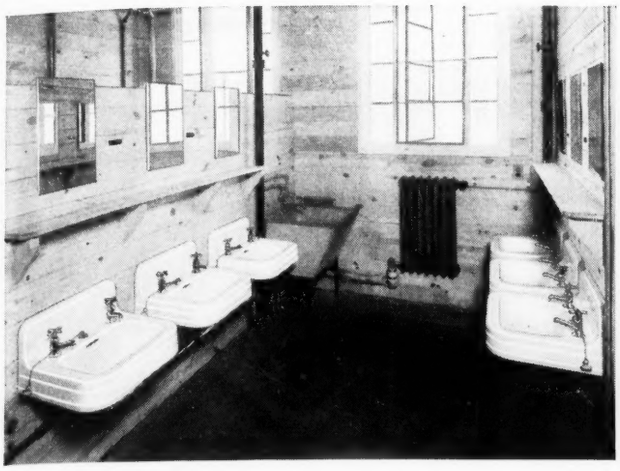


The amount reported during the current period was divided as follows: 32 new hospitals, of which 31 reported costs of $11,038,965; 60 additions, of which 59 reported costs of $11,665,233; five alterations costing $201,000, and four nurses' homes, of which three are to cost $445,000.

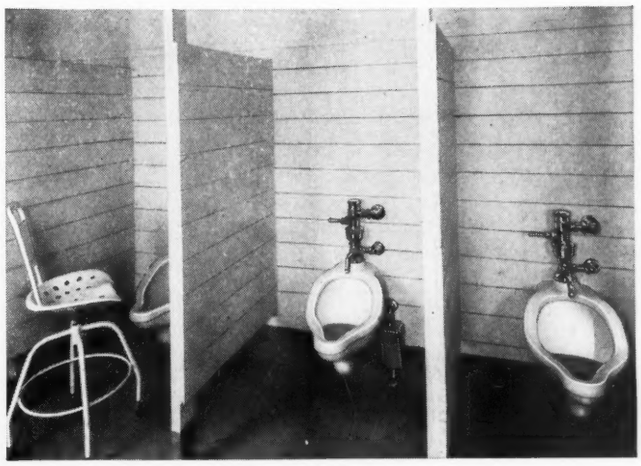
As may be seen from the accompanying figures, the price of building materials as measured by the *New York Journal of Commerce* index has continued to boom, reaching a peak of 124.4 on October 18. On Oct. 19, 1940, the price of building materials was 109.4.

Grain prices took a decided drop in the five weeks' period under review from 88.1 to 80.9. General food prices dropped from 92.1 to 91.3 and textiles dropped from 96.8 to 95.7. Fuel, on the other hand, advanced nearly a point. Drugs and fine chemicals remained almost unchanged, according to the index recorded in the *Oil, Paint and Drug Reporter*.

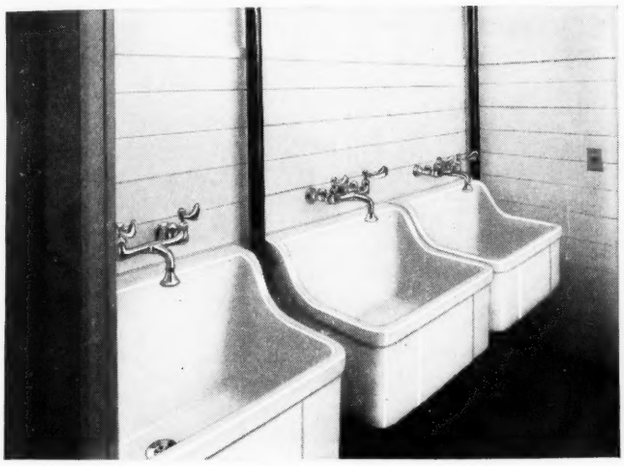
For Army Hospitals too
IT'S CRANE!



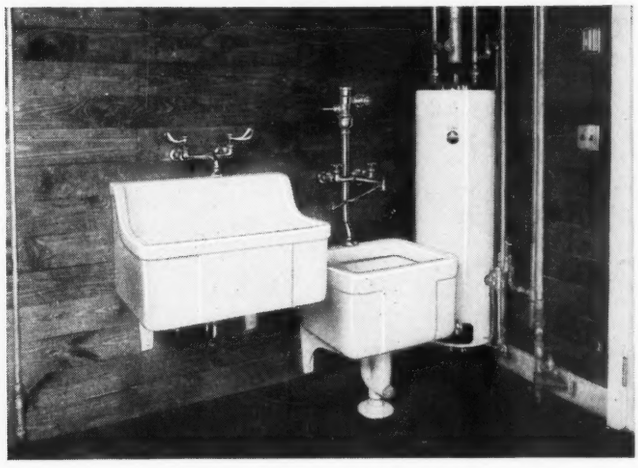
★ *Lavatories in wash room*



★ *Prophylactic Receptors in G-U clinic*



★ *Scrub-up and Surgical Sink for operating room*



★ *Scrub-up and utility sink with water heater in morgue*

● The lumber may be rough—the building lacking in fine appointments, but hospitals in army camps have this in common with modern hospitals everywhere—there can be no compromise in the quality of the plumbing equipment. Crane hospital plumbing is recognized as the last word in modern equipment. Duraclay fixtures, specially designed for hospital use are proving their value in improving asepsis—in lowering maintenance cost. Consult your Crane catalog or call the nearest Crane Branch for latest information on the complete line of Crane equipment for hospitals.

CRANE

CRANE CO., GENERAL OFFICES:
836 S. MICHIGAN AVE., CHICAGO
VALVES • FITTINGS • PIPE
PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky., Alloys F. Branton, M. D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Accounting

Question: Approximately 15 per cent of the gross operating income of the hospital is for services rendered to out-patients. Is it correct to compute the cost per patient day by dividing the total operating expenses by the number of patient days?—M.D., Mich.

ANSWER: No. The operating expenses should be apportioned between the in-patients and out-patients. It should be noted that the expenses of nonrevenue producing departments, such as administrative, laundry and housekeeping, should be apportioned to the main groups on an equitable basis. Furthermore, newborn infant costs also should be recognized by estimating, for example, four infant days as equal to one adult day.—ROBERT PENN, C.P.A.

Nonconformist

Question: We have on our staff an industrial doctor who divides his time between the factory and his private practice and who maintains he does not have time to keep records. He is apparently indifferent to hospital standardization. What suggestions have you to induce him to keep his records up as the rest of the staff do?—K.G., Iowa.

ANSWER: Every physician, regardless of his particular work or specialty, should be held responsible for a complete and comprehensive report on each patient he treats in the hospital. He may not necessarily write the medical record himself but, if not, he should see that such a record is produced promptly and accurately. All this, of course, should be in accordance with the policy recommended by the medical staff in its by-laws or regulations and approved by the governing board of the hospital. Having agreed to such regulations, the doctor should obligate himself to carry them out in an acceptable manner. Failing this and after every reasonable means of inducing him to comply with regulations has been exhausted, he should be suspended or dropped from the medical staff until such time as he will consent to comply with the requirements.—M. T. MACEACHERN, M.D.

Eight Hour Shifts

Question: What are small hospitals doing about the nursing situation? Are any of them using a straight eight hour shift?—C.E.G., N.J.

ANSWER: The study of personnel in small hospitals made by the *American Journal of Nursing* and the American Nurses' Association in the fall of 1940 gives information to the effect that some hospitals with less than 100 beds have three eight hour shifts with straight working hours for general staff nurses.

In this study, questionnaires were received from 402 hospitals of less than 100 beds and without schools of nursing. Of these hospitals, 321 reported as to the working hours of general staff nurses; 147 of the 321 hospitals, or 45.8 per cent, reported having three periods of duty in each twenty-four hours. Twenty-seven of the 147, or 18.4 per cent of the hospitals reporting three eight hour shifts in the twenty-four hours, had straight working hours in each of the three shifts for general staff nurses.—ERNESTINE WIEDENBACH.

Sterilizing Technic

Question: What is the best method of sterilizing scissors, needles, knife blades and cutting edge instruments?—C.W.R., N.C.

ANSWER: Cutting edge instruments can be sterilized satisfactorily by using any of the following technics in their order of preference based upon absolute sterilization with a minimum of deterioration of the cutting edge.

1. Heat at 320° F. for one hour in a dry heat sterilizer. The instruments may be placed: (a) on a hot aluminum plate enclosed in a suitable oven (this method is preferable); (b) in an oil sterilizer (such sterilizers are smelly, messy and a distinct fire hazard), or (c) in a hot air oven (these sterilizers are slow and heating is likely to be spotty).

2. Soak the clean instruments for eighteen hours in any of the following solutions: (a) a good commercial solution prepared for the purpose; (b) a solution made of sodium tetraborate, 50 gm., and formalin, 10 per cent, q.s. 1000 cc.; (c) a solution made of formalin, 38 per cent, 130 gm.; potassium nitrite, 0.15 gm.; sodium hydroxide, 0.012 gm., and ethyl alcohol C.P., 95 per cent, q.s. 1000 gm.; (d) zephiran, 10 per cent, 10 cc.; potassium nitrite, 5 gm., and distilled water q.s. 1000 cc.

The first three solutions have the disadvantage that time must be permitted for the germicide to evaporate before the instruments are used because formaldehyde is irritating to the tissues. The last named solution is particularly advantageous for ophthalmological instruments because the germicide is not irritating to the eyes and the instruments do not have to be dry before use.

3. Boil for fifteen minutes in a solution of 2 per cent sodium carbonate.—CARL W. WALTER, M.D.

Superintendent's Duties

Question: To what extent should the nurse superintendent in a hospital of 63 beds be expected to give anesthetics, do purchasing, collect accounts, plan meals, supervise the housekeeping, compound prescriptions and do other nonadministrative work? I just cannot seem to get a minute to make any outside contacts for the hospital or to do any constructive planning.—R.T., Ore.

ANSWER: Most of us nurse superintendents in small hospitals try to carry too big a load and, consequently, become a "jack-of-all-trades and master of none."

A 63 bed hospital should have: (1) a bookkeeper who will follow accounts, discussing delinquents with the superintendent; (2) a nurse or physician anesthetist, as the state law requires; (3) a dietitian-housekeeper, and (4) if the volume of prescriptions warrants it, a pharmacist; otherwise, a local pharmacy should fill prescriptions. The superintendent could then attend to purchasing and administrative duties.—GLADYS BRANDT.

Housekeeping Supervision

Question: In small hospitals who has charge of the housekeeping?—H.N.M., Conn.

ANSWER: There are several suggestions as to duties best combined with the housekeeping department in the small hospital. The two most frequently suggested are the combination of superintendent of nurses and housekeeping or dietitian and housekeeping. The latter combination, however, often does not work out well, causing much confusion between the nursing and the dietary departments. Probably the better combination is that of housekeeper-superintendent of nurses.—JEWELL W. THRASHER.

A Matter of Ethics

Question: Is it a good policy to give business, such as insurance, milk, produce or legal matters, to a member of the board?—E.R.C., Mich.

ANSWER: Normally, it is not good ethics for a board member to do business of any kind with the institution with which he is connected. However, if assignments are made on the basis of bids and contracts, I can see no harm coming from it. When work is turned indiscriminately to a board member, jealousy and ill will are engendered among other businesses having similar products to sell. I think the general rule should be that board members should forego all business with the institution except such business as comes in through competitive bids.—JOSEPH G. NORBY.

LOOKING FORWARD

Welcome, I.A.H.A.

THE formation at Atlantic City of an Inter-American Hospital Association to further co-operation among the hospitals of South, Central and North America brings to realization a long cherished dream.

It is confidently expected that the Inter-American Hospital Association will soon become an important link in strengthening the cultural bonds among the Americas. The officers are well chosen: Dr. José Jácome of Colombia, president; Dr. Frederico Gómez of Mexico, vice president; Felix Lamela of Puerto Rico, secretary-treasurer, and Dr. Malcolm T. MacEachern of the United States, honorary president.

An advisory committee has been formed which represents the A.H.A., the A.C.H.A. and the Inter-American Hospital Association. This indicates close collaboration among the three organizations.

Among the first tasks facing the new organization are the following: to foster the growth of national hospital associations in each of the American republics, to arrange additional inter-American institutes in the Latin American countries, to hold biennial congresses and to provide fellowships for travel and study.

Personal dues ($2 per year) and institutional dues ($5 per year) are low. It would be a fine indication of comradeship and cooperation if the hospital administrators of the United States and Canada would join the new association in large numbers. Dues may be sent to Doctor MacEachern.

Supplies and Equipment

AS REPORTED elsewhere in this issue, the federal government has expressed, through various officials, a desire to do everything possible to maintain the service of hospitals during the current emergency. "Everything possible" must be interpreted in terms of the current situation and the judgment of different officials as to the amount of effort that will be required to defeat Hitler. The Supply Priorities and Allocation Board is apparently determined not to underestimate the job it faces.

We in the hospital field must not underestimate it, either. We must make every possible effort to co-operate in the present national effort and to continue to merit the preferential treatment that we are receiving at the hands of the government.

The resolution on this subject adopted at the recent Atlantic City convention should become the guide of all hospitals. This resolution pledged the hospitals to analyze their needs carefully (eliminating all wanted items that are not strictly necessary), to eliminate all possible waste, to keep inventories down to actually indicated needs and to give full cooperation in the national interests during this time of emergency.

The maintenance and repairs order was recently amended by O.P.M. to give hospitals an A-10 rating for all needed operating supplies. Since hospitals are only one of 22 large industries that are included in this order, it is impossible for federal officials to maintain minute control over the use of the plan. Hospitals are, therefore, put on their honor to use the plan only when necessary.

If some hospitals abuse the special privileges extended to them, the result will be greater difficulty for all institutions—closer control by federal officials and more paper work for the hospitals.

There is a war to win and we in the hospital field are determined to do our part to see that it is won as quickly and effectively as possible. This is the only humanitarian viewpoint possible.

The Time for Action

FOR the last two years much time and energy of the members of the Commission on Hospital Service, the Council on Hospital Service Plans and other national leaders in the hospital field have been devoted to establishing a proper relationship between the American Hospital Association and the approved plans. The unanimous action of the house of delegates in Atlantic City may be interpreted as a vote of confidence given to those who have steered the Blue Cross movement during the past few years.

The plans and the American Hospital Association have now established clear-cut definitions of their

respective fields of interest and responsibility. An excellent Hospital Service Plan Commission has been elected. Plans all over the country, including some of those which in the past have been critical of the work of the commission, are now rallying to its support.

Under these propitious circumstances, the work of the commission should go forward rapidly and constructively along the following lines: development of ward service plans that will extend the Blue Cross service to lower income groups; reciprocity among plans and more intensive work on national enrollment; joint public relations programs for plans and the hospitals; further attention to uniform accounting, terminology and various details of office management.

The increasing interest in medical service plans and the fact that in some areas the hospital service plans are being requested to cooperate in making medical service available indicate the need for compiling information on this subject for the guidance of the various plan executives and trustees.

The recent endorsement of the Blue Cross movement by Paul V. McNutt, federal security director, and its recognition in various other ways by federal and local government officials indicate the growing importance attached to the movement. This should be stimulated and encouraged, since effective ward service plans may eventually require some governmental assistance if they are to meet the problem fully and effectively.

A Working Library

THE handsome display of books that featured the exhibit of the Bacon Library of the American Hospital Association at Atlantic City was not designed for decorative purposes only. The books have been collected so that they can be circulated. Anyone in the hospital field, whether he lives in Puerto Rico or British Columbia, can borrow books from the library.

A list of the new books received during the past year has been prepared by the librarian and is available on request to her. In selecting books for purchase, the library committee has given special emphasis to the fields of personnel administration, public relations, business management (including purchasing and accounting) and medical economics.

If you wish help in solving problems of hospital administration, use the facilities of your library. If you have suggestions for improving the service of the library or adding to its collection of books, the library committee will receive them gratefully.

The Banquet Speaker

ONE need not be priggish to have felt a keen sense of disappointment in the speaker who addressed one of the banquets held at Atlantic City. The talk consisted of sophomorish attempts to ridicule the president and president-elect of the association, an insipid attack upon the president of the United States, ridicule of Presbyterian Hospital, Chicago, and supposedly humorous remarks about the dishonesty of the legislature of the speaker's home state. All of this was loosely held together by a series of antique, risqué stories.

The address might not have been so out of place if the occasion had not otherwise been impressive and dignified. A distinguished array of hospital leaders of South, Central and North America filled the head table. The ceremony of the dedication of the colors was sober and inspiring.

America is not so intellectually barren that it is necessary for important organizations to resort to speakers of such caliber. As many similar banquets have indicated, men of culture, wit and grace are available who have as much entertainment value and far more propriety.

Cooperation Opens New Vistas

THE enrollment of the employes of General Motors Corporation in approved Blue Cross plans is an important event; first, because half a million people will become eligible to Blue Cross protection and, second, because it demonstrates the need for cooperation among the various plans and the fact that such cooperation can be obtained. In the General Motors enrollment, 22 approved Blue Cross plans are participating.

Many industrial and agricultural organizations in this country have employes or members who are widely distributed geographically and who would profit by Blue Cross membership. No attempt should be made to put hospital service plans in a strait jacket, but it would be of decided benefit in approaching these national enterprises if there were more uniformity in the rates and benefits offered by the various plans. Some of the present variations seem to be arbitrary and of little real significance.

The General Motors enrollment also illustrates the need for understanding between management and labor in reaching decisions of this kind. Enlightened management has long had a sense of its responsibility for hospital service. Organized labor also has evidenced a definite interest in the health of its membership and has joined with management to make the benefits of nonprofit hospital service plans available.

The boards of directors of Blue Cross plans usually have been composed of hospital administrators, hospital trustees, physicians and representatives of the general public. The last mentioned group often has been chosen from among the large contributors to hospitals and the large employers of labor. Increasingly in the future we shall doubtless see official representatives of labor sitting on the boards of Blue Cross plans.

Hospitals and Priorities

A Summary to Date

ALDEN B. MILLS and RUTH HILL ZIMMERMAN

A SWEEPING amendment to the maintenance and repairs order granting an A-10 priority rating to hospitals for all "operating supplies" as well as for all materials they require for maintenance and repair of equipment was a startling and unexpected development in the priorities situation during October.

Hospitals, clinics and sanatoriums are now given better protection by this new order and by the amended Health Supplies Rating Plan than almost any other civilian industry or service. Such preferential treatment involves serious moral obligations for hospitals and for the firms that furnish them with equipment and supplies. The rating under this new operating supplies plan is extensible by dealers and distributors to manufacturers and suppliers.

Washington's Reasoning

To understand the position of hospitals in relation to priorities, it is necessary to know the attitudes of those who determine policy in Washington. The recent reorganization of O.P.M., the creation of S.P.A.B. (Supply Priorities and Allocation Board) and the appointment of Donald M. Nelson as executive officer of S.P.A.B. and as director of priorities in O.P.M. have given a clear indication of the dominant viewpoints.

Stated succinctly, these viewpoints are as follows:

1. The United States is determined to defeat Hitler at whatever cost.

2. The cost is going to run far higher than had been originally estimated. It will be necessary to sacrifice most luxuries and to cut down on many goods and services heretofore considered necessities. (Note, for example, O.P.M.'s refusal to permit construction of the pipeline wanted by Secretary Ickes.)

3. Construction or expansion of plant that does not contribute to the defense effort must be postponed until after the emergency. If, as seems likely, we have a serious post-war depression, we should have a substantial backlog of governmental and nongovernmental construction and expansion projects ready.

4. There is vital need for the continued effective functioning of hospitals to protect the health of the whole population (particularly of workers engaged directly in defense production), to maintain civilian morale to care for possible casualties in areas subject to attack or major catastrophe and to continue and expand training programs for doctors, nurses and other technical persons needed in the nation's service.

5. To achieve the continued effective functioning of hospitals, all needed steps should be taken that are possible and consistent with the major objective.

The recent reorganization puts Donald Nelson and Leon Henderson in positions of increasing responsibility and authority. Both of them have long been urging that defense needs be taken more seriously. In their new positions they can, if necessary, demand rather than urge. A survey is now under way to determine present supplies and to preserve them against future needs.

Construction Restricted

A significant development is the S.P.A.B. announcement on October 9 of a new policy under which no public or private construction projects that use substantial quantities of critical materials, such as steel, copper, brass, bronze and aluminum, may be started during the emergency unless these projects either are necessary for direct national defense or are *essential to the health and safety of the people*. This policy was decided upon after a comprehensive survey by S.P.A.B. of the entire field of construction to see what quantities of critical materials are used, how much money is involved, how much labor is employed and what defense and civilian needs are being met.

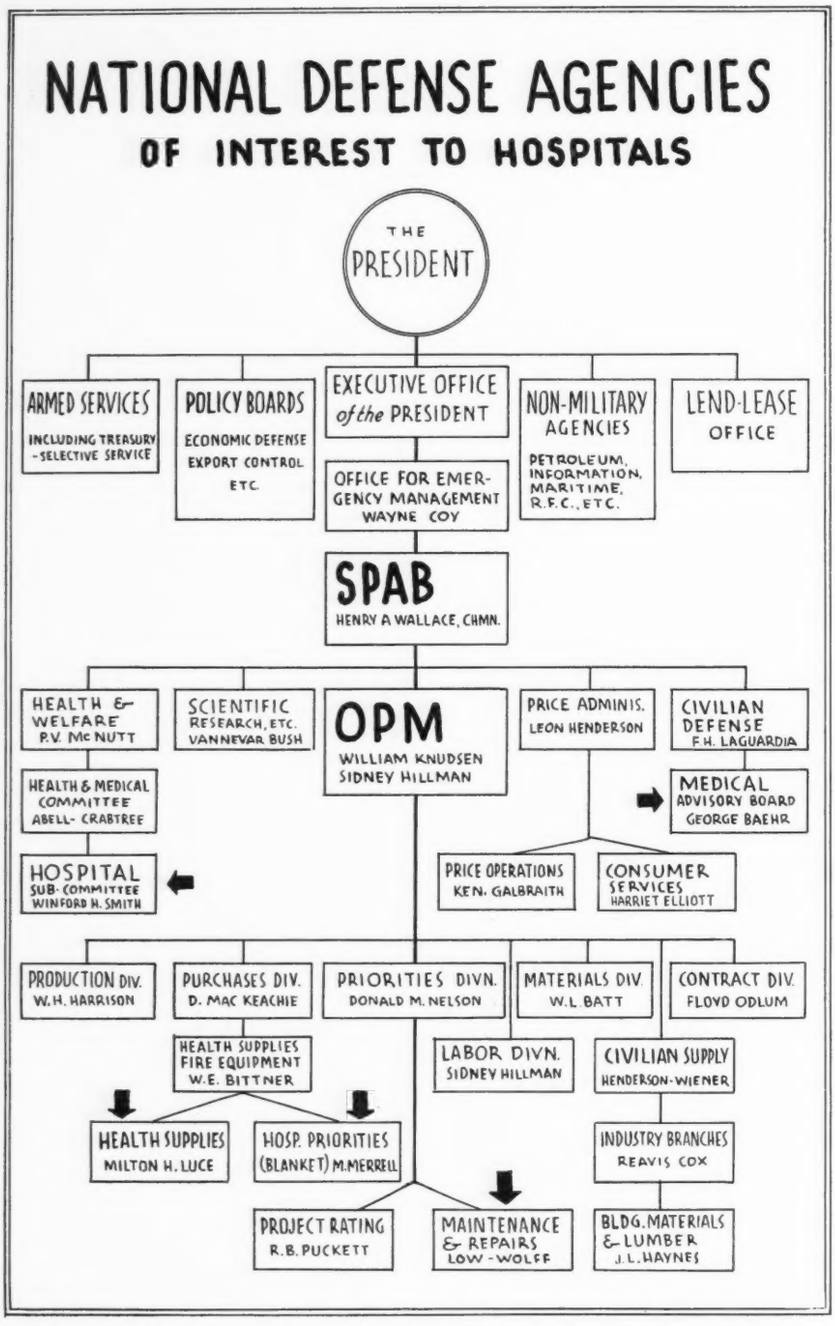
The new maintenance and repair order issued on October 16 (Preference Rating Order P-22, Amended) drastically changes the situation as far as hospital supplies and equipment are concerned. Like the old order, it permits hospitals (as well as schools, charitable institutions, manufacturing plants, carriers and other groups) to use an A-10 priority to obtain needed materials and supplies for maintenance and repair. But it goes far beyond this and allows them to use the same priority to obtain "operating supplies," which means "any material which is essential to the operation of the producer's business and which is consumed in the course of such business."

Excluded Items

Excluded from the definitions of "maintenance," "repair" and "operating supplies" are: (1) items that are physically incorporated into any product of the producer; (2) material for the improvement of a producer's property or equipment through the replacement of existing material with better material; (3) material for additions to or expansion of the producer's property or equipment, and (4) material that heretofore has not been carried on the producer's books under "maintenance," "repairs," "operating supplies" or their equivalents.

This really means that hospitals can get anything they need under the plan except materials required for new building and expansion. A decision confirming this interpretation of the order is expected shortly.

Hospitals cannot use this priority to increase their inventories beyond a "practicable working minimum" (and in no case beyond the aggregate dollar volume of items of the same class carried on the hospital's books at the close of the fiscal year ending during 1940). The priority cannot be used except when necessary to obtain needed material nor can it be used to obtain scarce materials when a substitute material can be used without serious loss of efficiency



The authority of the national defense agencies, issuing from the President, centers around S.P.A.B. and O.P.M., as illustrated on the chart above. Those agencies of especial interest to hospitals are indicated by the arrows.

or when simplification of design would save on scarce materials.

The procedure for using the new order is simplicity itself. First, the hospital officers should obtain copies of the order (from Washington or from the local branch office of the Division of Priorities) and study it carefully. Then, having satisfied themselves that a particular purchase falls within all the limitations of the plan, they need merely to endorse on the original and on all copies of the purchase order or contract the following words:

"Material for Maintenance, Repair or Operating Supplies—Rating A-10 Under Preference Rating Order P-22, as amended, with the terms of which I am familiar."

This endorsement and the order itself are then signed by a "responsible official duly designated for such purpose by such producer or supplier." That is all. It does not need approval by any government official.

This endorsement should not be routinely placed on all hospital orders. The penalties for applying the preference rating in willful violation of the terms and provisions of this order or for willfully falsifying any records are drastic. In addition to the usual penalties under the criminal code, a violator may be prohibited from obtaining further assistance under any priorities orders.

Hospitals and their suppliers are put on their honor to obey the order. Each of them must keep a separate file of these orders available for inspection and audit by representatives of O.P.M.

Manufacturers, dealers and distributors can use the new preference rating in exactly the same manner that hospitals do. They must be careful, however, not to order more goods or materials than they need to fill rated orders obtained by them.

Because of this limitation and of the inconvenience that it will cause to manufacturers and distributors, it is probable that all manufacturers who now have an A-10 rating under the Health Supplies Rating Plan will prefer to continue under this plan. Thus, they will be able to replenish their stocks in reasonably normal fashion without waiting until they have accumulated a sufficient number of rated orders to justify a purchase. The Health Supplies Plan gives the A-10 rating to the manufacturer, who is expected to use it to keep his stocks up to normal levels; under the new maintenance, repairs and supplies order the hospital or other consumer is given the rating and must pass it back to the manufacturer.

The organization and major personnel of the defense agencies are indicated in the accompanying chart. O.P.M. is the most important office in Washington, so far as hospital supplies and equipment are concerned. Other groups, however, will also affect hospital affairs.

The Health and Medical Committee, of which Dr. Irvin Abell is chairman and Dr. James A. Crabtree is executive secretary, has now become an advisory group to the new Office of Defense Health and Welfare Services. A subcommittee on hospitals in this committee is headed by Dr. Winford H. Smith of Johns Hopkins Hospital.

Since the establishment of S.P.A.B. there has been an increased emphasis on allocation of scarce raw materials rather than on priorities alone. While Mr. Nelson has made it clear that

existing priority rules and regulations and preference rating orders are to remain in effect until changed conditions warrant their withdrawal or alteration, it is expected that, within the limits of defense demands, S.P.A.B. will work out a means of dividing or allocating the total supply of the various scarce raw materials for various purposes and in various proportions of previous consumption. However, even with a system of allocation of materials, some means of timing or priority system will be needed.

Health Supplies Plan

The Health Supplies Rating Plan was announced on August 25 and was revised and extended on September 30. The plan now gives to producers of 25 classifications of health supplies for medical, surgical, dental and veterinarian use and to their suppliers the opportunity to obtain an A-10 preference rating, if this is needed. In the list that follows, classifications marked with an asterisk are new, and those items in italics are extensions of classifications set up in the original list.

*1. Acoustical aids
2. Anesthesia apparatus and supplies
*3. Atomizers (medical use only)
4. Biologicals, antitoxins, serums, *sterile ampules* and *intravenous solutions*
5. Clinical thermometers
6. Diagnostic equipment and *supplies*
*7. Hospital carts, racks and charts
8. Hypodermic syringes and needles
*9. Infant incubators
10. Instruments
*11. Invalid chairs, walkers and crutches
12. Laboratory equipment and supplies
13. Medicinal chemicals (limited to medical use only)
14. Operating room *supplies* and equipment
*15. Ophthalmic products and instruments
*16. Physical therapy equipment (limited to medical use only)
*17. Respirators, resuscitators and iron lungs
18. Rubber hospital sundries
*19. Sickroom furniture, equipment and supplies
*20. Splints and fracture equipment
21. Sterilizers, *blanket* and *solution warmers*
22. Surgical dressings and adhesive plasters
*23. Surgical and orthopedic appliances (including artificial limbs and arms)
*24. Sutures and suture needles
25. X-ray equipment and supplies.

Any manufacturer who wishes to avail himself of the assistance offered by this plan should make written application to the Health Supplies Section, O.P.M., for Form PD-79, and at the same time should file a complete catalog showing as nearly as possible all the finished articles he manufactures. Once the rating is authorized, it can be extended by filing certain required reports every three months.

New construction is not covered by either the Health Supplies Rating Plan or by the amended Repairs, Maintenance and Supplies Plan. A hospital wishing to modernize its facilities or to construct additional buildings will probably not be able to get sufficient materials in the future without a preference rating certificate.

Such a certificate will be awarded for an entire building project or, in cases of necessity, a high enough rating may be granted for special scarce items, such as copper, to secure their delivery. It may be obtained by addressing a letter to the Project Rating Section, Priorities Division, O.P.M.

The letter should contain full and accurate information on all of the following points: (1) name of owner; (2) location of principal office; (3) location of proposed plant or expansion; (4) materials to be produced or services to be provided; (5) justification of project as being necessary to defense; (6) description of what is contemplated; (7) type of material and equipment required in specific quantities and value, if possible, particularly of items on the critical list; (8) estimated date of completion; (9) estimated cost to complete: [a] cost for materials, [b] total cost; (10) per cent complete at present.

The crux of this application, of course, is item 5, "justification of the project as being necessary to defense." Hospitals have been getting some project ratings varying from a low of B-4 to a figure well up in the A scale. Of course, a hospital that needs new facilities so that it can take care of a greatly increased load of workers from near-by defense industries, army camps or similar activities would probably have little difficulty in obtaining a high project rating.

Other hospital activities that might well be considered as important defense activities are: expansion of nursing education, particularly if expanded with aid from federal funds; training of dietitians, physical therapists, nurse anesthetists, x-ray and laboratory technicians and other personnel needed in Army, Navy or other governmental hospitals; examinations under Selective Service, and participation in the new program for rehabilitation of draft rejectees.

Associations Back High Rating

The committee on priorities of the Hospital Industries Association and the American Surgical Trade Association passed a resolution on the subject of hospital building materials at its September 10 meeting. This urged that hospitals be given preference ratings sufficiently high so that they may be able to obtain needed amounts of fixed equipment of all types.

At a meeting in October the committee on priorities adopted a resolution calling upon the members of the H.I.A. and the A.S.T.A. to do everything possible: (1) to discourage hospitals from overbuying scarce items; (2) to counsel with hospitals regarding methods of reducing their needs; (3) to aid hospitals to keep present equipment and machinery in use; (4) to aid them to reclaim or remake equipment and supplies; (5) to help them avoid waste and loss; (6) to avoid statements that will cause hospitals to be unduly apprehensive about prices or supply of materials, and (7) as individual firms, to take all other steps to assure equitable distribution of the available quantity of supplies and equipment.

At its recent Atlantic City convention, the American Hospital Association adopted a resolution pledging that hospitals would do everything in their power to conserve equipment and supplies, would avoid excessive inventories and would cooperate as fully as possible in the nation's defense effort.

Basic

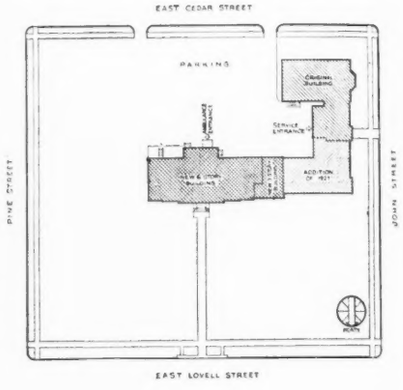
THIELBAR and FUGARD
Architects, Chicago

STONE and WAGNER, INC.
Associate Architects, Kalamazoo, Mich.

CONSTRUCTION DETAILS

GENERAL DATA: New six story unit designed as center of new group of buildings. Attached to existing hospital of 51 beds, the addition has 72 beds for adults, 18 for children and 30 bassinets. One of two general hospitals serving city of 50,000 with an outlying district of 70,000 population. Located in heart of city.

CONSTRUCTION: Frame, reenforced concrete; floors, concrete beam and slab with



Structure

for New Group

A. F. WAY

Superintendent
Bronson Methodist Hospital
Kalamazoo, Mich.

tile fillers; exterior walls, brick with tile backup and limestone trim; interior partitions, gypsum block, structural tile and glazed brick. Windows, steel, double hung; in large wards and assembly room, steel casement. Doors, flush birch and oak with metal frames; fire doors, Underwriters' Laboratories' label hollow metal.

WALLS: Operating rooms and obstetrical rooms, ceramic tile. Around built-in sterilizers, terra cotta block. Kitchen, ceramic glazed tile; north ward, glass block; other walls, plaster.

FLOORING: Operating, obstetrical, scrub-up, work, bath and service rooms and kitchen, terrazzo; elsewhere, asphalt tile. Sub-basement, concrete.

HEATING: High pressure steam boilers with ram type of stokers, high pressure to laundry and sterilizers, medium pressure to cookers, low pressure for heating. Cabinet copper fin convectors. Stair halls, operating rooms and obstetrical rooms, cast iron radiators. Zone control.

LIGHTING: Patients' rooms, semi-indirect; offices, indirect; laboratories, fluorescent.

REFRIGERATION: Main refrigerators, central machinery; small refrigerators and morgue, separate freezing units.

CALL SYSTEMS: Lamp annunciator, doctors' call, doctors' in-and-out register.

ELEVATORS: Up-down tandem collective with automatic two-way leveling automatic doors and speed of 150 feet per minute. A.C. current. Two food dumb-waiters; one central supply dumb-waiter.

LAUNDRY: Two washers, two tumblers, two extractors, two presses, starch kettle, soap kettle, one ironer.

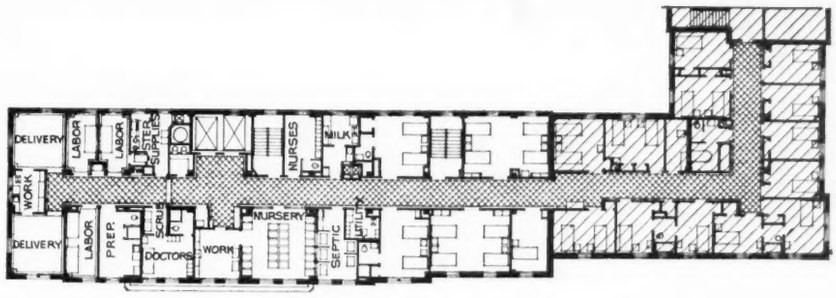
KITCHEN: Diet kitchen range, range, fryer, bake oven, steam cooker, steam kettle, bain-marie, steam table, cold table, coffee urn, toaster, cafeteria table, dishwasher, refrigerators.

X-RAY DEPARTMENT: Complete diagnostic unit with additional cystoscopic tables, completely equipped dark room, film storage and viewing room.

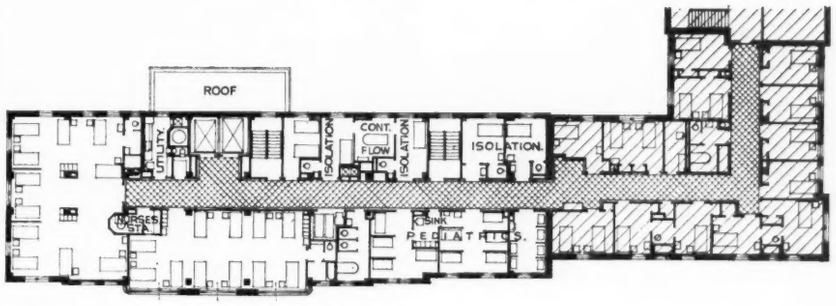
BUILDING COSTS: New addition..$255,818
Alterations to old building..... 15,000

Total building cost.....$270,818
Cost per cubic foot: total, 53.9 cents; heating, 6.74 cents; plumbing, 5.73 cents; wiring, 3.34 cents; elevators and dumb-waiters, 6.05 cents.
Cost per bed of new addition, $2,665.

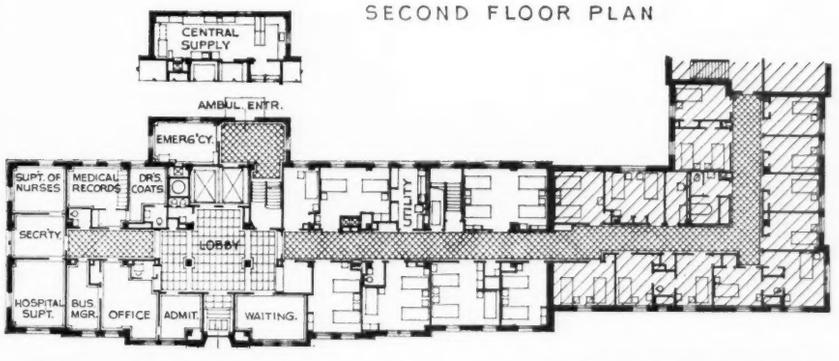
EQUIPMENT COSTS (laundry, kitchen and sterilizing), $29,467. Cost per bed, $279; cost per cubic foot, 5.7 cents.

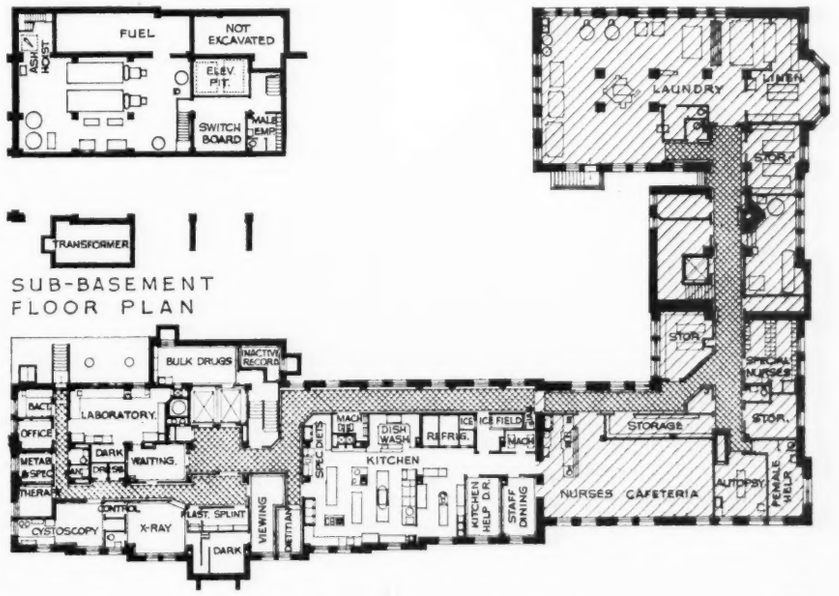


THIRD FLOOR PLAN



SECOND FLOOR PLAN





SUB-BASEMENT FLOOR PLAN

BASEMENT FLOOR PLAN

Must We Raise Rates?

"Yes!" Is the Consensus

HOSPITAL rates are going up. That is the crystallized conclusion drawn from a quick nationwide survey made recently by The MODERN HOSPITAL to determine the trend in the field as a whole.

Pressed by economic conditions that demand pay roll increases and yet present a rapidly dwindling number of revenue sources, restricted by priority ratings that ration supplies and that, indirectly, raise commodity prices, crippled by nurse and intern shortages and burdened by unseasonably high occupancy, hospitals the country over are considering rate increases. Those that have acted during the last six months have raised their rates, on an average, 50 cents a day.

Laboratory, x-ray department and operating room fees, flat rates for maternity cases, charges for drugs and dressings, all have been increased in many hospitals to offset a budget deficit.

Grace Hospital, Detroit, has boosted flat rates in obstetrics for four bed rooms from $50 to $55 and for double rooms from $60 to $65; representatives of the hospitals in Birmingham, Ala., are considering a 20 to 30 per cent increase in operating room fees, anesthesia service and laboratory charges.

California Boosts Extra Charges

Most of the hospitals in California, according to Thomas F. Clark, executive secretary of the Association of Western Hospitals, have increased the rates for extras and operating room charges. A revised scale for advancing the rates for x-ray examinations is under consideration, he says.

F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J., does not approve of raising such charges. "We raised private and semiprivate room rates 50 cents a day on June 9," he reports. "However, we did not feel it desirable to raise extras, such as fees for the operating room and for laboratory and x-ray examinations, since we believe that these are high enough now and that such charges cause most of the arguments over hospital bills."

Although the mean increase for all hospitals included in this survey is 50 cents a day, individual increases range from $1 a day for private rooms to 25 cents a day as a basic minimum raise. Central Washington Deaconess Hospital and St. Anthony's Hospital, Wenatchee, Wash., jointly agreed on a 10 per cent raise on all private rates.

The hospitals in Milwaukee have discussed in great detail the proper basis for increases. Joseph G. Norby of Columbia Hospital has pointed out that a 50 cent increase on a $10 room is only 5 per cent of the room charge while a 50 cent increase on a $3 room is an increase of 16 2/3 per cent. Most of the Milwaukee hospitals are, therefore, making their increases on a percentage basis.

Having effected one increase in rates of 50 cents a day, Luther Hospital, Eau Claire, Wis., anticipates another advance to meet costs.

W. B. Coffey, business manager of Coffey Memorial Hospital, Portland, Ore., reporting a rate increase to private patients of $1 a day, writes that "increased costs and raises in salaries that have been made more than offset this rate change."

Alarmed by the steadily increasing cost of operation, Frank W. Hoover, superintendent of Decatur and Macon County Hospital, Decatur, Ill., recently sent out a questionnaire to 21 midwestern hospitals in regard to increases in room rates. Of the 18 hospital administrators who replied, 14 reported an average increase of 11 per cent. One hospital had increased its flat rates 5 per cent and operating room charges in another institution had been raised from $15 to $20.

In the minority are those institutions that have taken no steps toward rate increases. In some cases all of the patients in these hospitals are government charges; in some care is given to indigent patients only, as in the case of City Hospital, Cleveland, and in others, such as the hospitals of North Dakota, the administrators feel that the low purchasing power of patients in that locale prohibits a raise.

May J. Heath, assistant superintendent of Greenville General Hospital, Greenville, S. C., sums up the situation for these institutions when she says: "Owing to the poor economic condition of a great many of our patients who are admitted to the wards, we have felt that any increase in rates should be delayed as long as possible. There is a possibility, however, that some adjustment will have to be made to overcome the increased costs our hospital is having to meet."

Joint Action Preferred

From the answers received, it is apparent that there is a decided tendency for the hospitals of a particular area to work jointly on this problem. In some areas, such as Evansville, Ind., the need for rate increases has been taken as the occasion for the hospitals to agree on uniform rates for all services that are comparable. Other areas in which joint action on the subject has been reported or is being considered include Chicago, New Orleans, Denver, Birmingham, Ala., Des Moines, Iowa, North Dakota, Portland, Ore., and Houston, Tex.

Many of the administrators who cooperated with The MODERN HOSPITAL in this survey believe that much of the present financial difficulty can be solved by economical use of supplies, equipment and personnel.

"We are trying hard to make up increased costs by increased savings, decreased waste and the substitution of materials for those that have become too high priced to purchase," L. M. Arrowsmith, St. John's Hospital, Brooklyn, N. Y., states.

Thomas F. Clark's comment is as representative of general opinion as it is succinct. "Progressive superintendents feel that the solution to the increase in operating costs is to carry out a rigid program of economy and simplification of procedure in all departments insofar as this can be accomplished without reducing service to the patient."

How to Handle Head Injuries

ERNEST SACHS, M.D., and FRANK R. BRADLEY, M.D.

Professor of Clinical Neurological Surgery, Washington University School of Medicine, St. Louis, and Superintendent Barnes Hospitql, St. Louis, Respectively

WITH the tremendous increase of head injuries resulting from automobile and airplane accidents, every hospital must be prepared to take care of such cases. Frequently, these patients are so ill that they cannot be transported to a hospital in which a neurosurgeon is located.

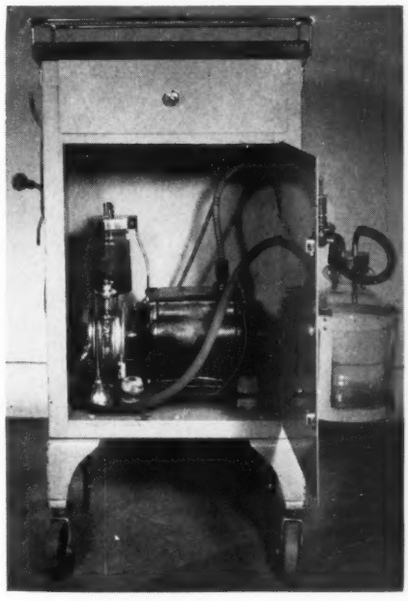
Fortunately, today the number of young men who have passed through a neurosurgical service in the course of their surgical internship is quite large and is constantly increasing, so that such cases can receive proper attention if the hospital has the necessary equipment. On the surgical service at Barnes Hospital, St. Louis, every intern during his one year surgical service spends five or six weeks on neurosurgery and every assistant resident during his two year service spends three or four months on neurosurgery. This time is ample for an alert house officer to become familiar with the fundamental principles of taking care of head injuries.

As soon as a patient with a head injury enters a hospital that has a neurosurgeon on its staff, he should be put on the neurosurgical service. Valuable time may be lost if such a patient is first admitted to the general surgical service. The practice that exists in some hospitals of admitting all surgical cases first to the general service is unwise; the admitting physician should assign the patient at once to the proper service.

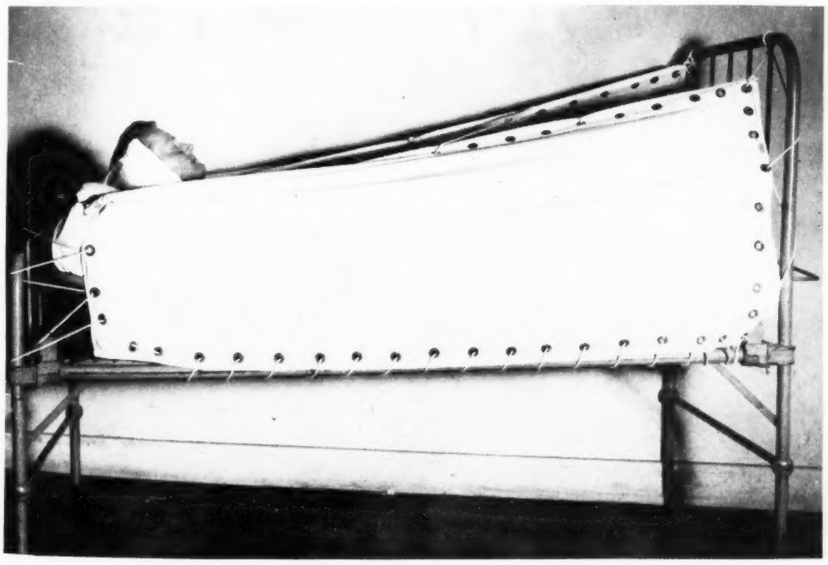
Every patient with a head injury, no matter how trivial it may seem to be, should be put to bed and observed for twenty-four hours. Ambulatory cases with small lacerations of the scalp that give no evidence whatever of intracranial disturbance need not be admitted, but if there is the slightest question they should be taken in and carefully watched. Occasionally, a severe head injury may manifest no symptoms for several hours. This may occur particularly when there is a slow subdural venous hemorrhage or a ruptured arachnoid. Either of these conditions may occur without fracture of the skull.

Immediately upon being put to bed, the patient's blood pressure and pulse should be taken and recorded; this should be repeated at frequent intervals for the first few hours. Nurses should be trained to take such readings. If the patient is unconscious, there should be provision to keep his airway clear by suction. In addition, an airway should always be at hand. There also should be readily available an efficient mouth gag; the usual wooden gag is much less efficient than a metal one.

These patients may be restless and can best be protected from falling out of bed by the use of canvas laced to the sides and ends of the bed. Heavy fish net may be used for this purpose in hot weather.



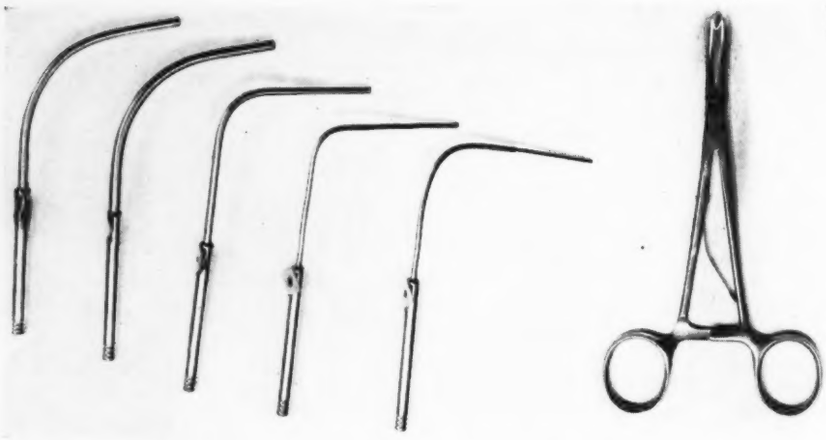
Suction machine often used on the wards to keep patient's airway clear.



Restless patients can be protected from falling by the use of canvas sides laced to the bed. In hot weather heavy fish net may be substituted for the canvas.

Restraining patients with leather restraints is undesirable and dangerous as a restless patient may develop serious abrasions. If the patient is extremely restless, a canvas binder laced about the chest is fully as effective, safer and more comfortable.

After the patient's general condition has been taken care of, a complete set of x-ray plates should be taken. Our routine is to take a fracture series in every instance. This consists of a right and left stereoscopic view of the head, an anteroposterior and one postero-anterior view (six plates in all). Dr. Sherwood Moore, head of the department of roentgenology at Barnes Hospital, has established this routine because he has found a fracture may be missed unless all these views are taken. Any head injury may become



Left: The holes in the handles of these metal suction tubes permit pressure to be released instantaneously. Right: Silver clip holder with clip in place.

a medico-legal problem and it is important, therefore, to take all possible precautions.

If the patient has a lacerated wound, the area about the wound should be properly shaved and covered with a sterile dressing. All too frequently wounds that are thought to be only minor scalp wounds are sewed up carelessly and then, when it is subsequently discovered that there is an underlying fracture, the surgeon has to work in a dirty field.

Still prevalent is the idea that ice should be applied to head injuries and many hospitals still go to great expense to provide ice helmets. In my experience, ice to the head in head injuries has no therapeutic value whatever. A simple ice bag for headache answers all ordinary purposes.

Head injuries with brain damage may be treated in one of two ways, conservatively and by operation. An essential part of the conservative treatment is the administration of hypertonic fluids. These should always be available. Those most frequently used intravenously are sucrose, 50 per cent and glucose, 10 per cent and 50 per cent; a saturated solution of magnesium sulphate may be used as a retention enema. We consider the administration of magnesium sulphate intravenously dangerous and never permit it to be used on this service.

If the patient requires operation, as in a middle meningeal hemorrhage or a ruptured arachnoid or a compound fracture with or without a lacerated dura, certain special instruments must be available. These are: (1) bone instruments for opening the skull; (2) some means of controlling hemorrhage from the brain, either silver clips or electrocoagulation (an electrocoagulation unit is not essential, though of great help, but silver clips are indispensable); (3) some form of suction apparatus so that the surgeon can do an effective debridement when there is a lacerated brain as in a compound fracture with torn dura.

In an emergency, the last named procedure can be accomplished with a catheter and an aseptic syringe (from 10 to 20 cc.). During the World War, suction of brain wounds was introduced by Dr. Harvey Cushing and he found a catheter with an aseptic syringe quite satisfactory. Far more effective, however, is a suction machine with metal tubes of varying sizes. If central suction is not available, some separate machine may be used. The suction machine usually used by nose and throat men, in our experience, is not powerful enough; consequently, we have had a special suction machine built that is noiseless and is available in case the central machine breaks down.

Most of these operations are carried out under local anesthesia so that novocaine (0.5 per cent) must be available.

In addition to the surgical needs of these cases, they present a major administrative problem that is different from that of any other group of patients. They often come without warning, brought in by the police or picked up by strangers. As these patients are frequently unconscious, no information, medical or social, is obtainable; their status has to be determined at a later period. A certain number of these patients with severe head injuries die within forty-eight hours without regaining consciousness and this makes the administrative problem even more difficult to handle.

Anesthesia in a Small Hospital

IDEALLY, an efficient department of anesthesia should have as its head a physician anesthetist, trained in anesthesia and devoting his entire time to this branch of medicine. As such, he acts as the consultant with the surgeon as to the type of anesthesia for individual cases, giving spinal and intravenous anesthesia and prescribing the preoperative medication. It is just as important to have a doctor of medicine as head of the department of anesthesia as it is to have a doctor of medicine as director of the x-ray department or the clinical laboratory.

The problem of the small community hospital of 50 beds, averaging about 60 to 80 surgical cases a month, can best be solved by employing a well-trained registered nurse anesthetist, working directly under the surgical supervisor.

Oxygen therapy might be included in the department of anesthesia, especially in the small hospital in which the nurse anesthetist has more leisure time.

The nurse anesthetist should keep abreast of the advances in anesthesia by availing herself of all articles pertaining to anesthesia in medical journals and the magazines devoted to anesthesiology.

The hospital's obligation to the doctor, the patient and the anesthetist is to make every effort possible to keep its equipment up to date; the nurse anesthetist should not be expected to struggle with antiquated equipment.

Rarely is it satisfactory to employ a part-time doctor of medicine, without special training, to give anesthetics, as his efficiency cannot compare with the trained nurse anesthetist.—GEORGE U. WOOD, *Peralta Hospital, Oakland, Calif.*

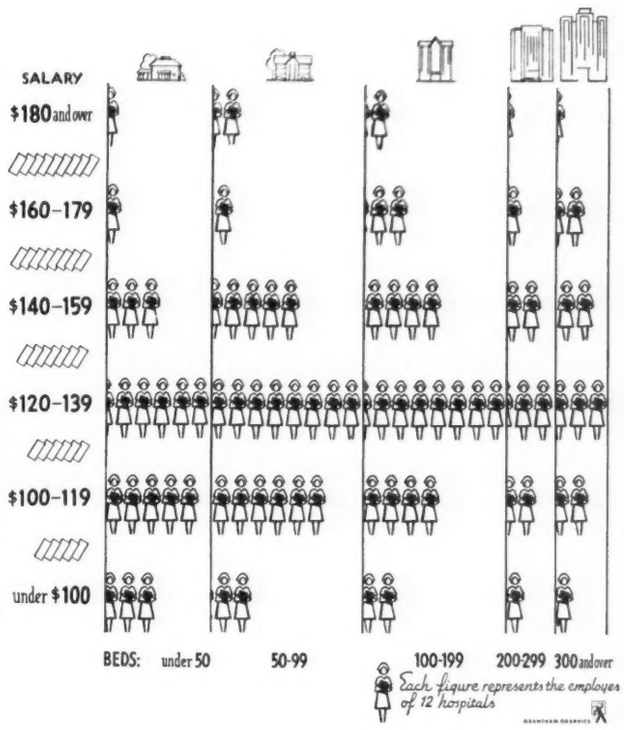
X-Ray and Laboratory Technicians

A National Study of Salaries

ALDEN B. MILLS

X-RAY and laboratory technicians receive about the same salaries, with the x-ray technicians usually getting from $2 to $14 per month more than the technicians working in the clinical laboratories. The average for x-ray technicians in 921 hospitals in the United States and Canada that sent in data for The MODERN HOSPITAL's salary study was $129 per month, including the fair cash value of whatever maintenance is provided. For laboratory technicians in 987 reporting hospitals the comparable figure is $122.

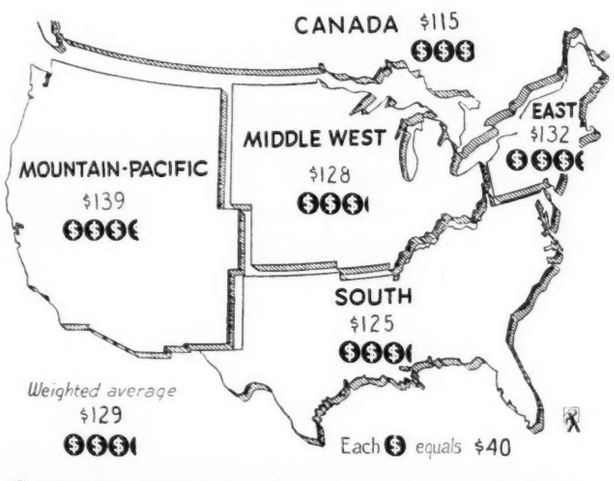
For x-ray technicians, the average salary for the country as a whole increases steadily in proportion to the size of the hospital for which they work, rising from an average of $112 in the smallest institutions reporting to a maximum of $136 in the hospitals of 500 beds or more. The highest average salaries in any one region and size group, however, were reported by nine hospitals of from 300 to 499 beds in the Mountain and Pacific states which pay an average of $153. The lowest salaries reported were those paid by seven Canadian hospitals of from 50 to 99 beds, whose average salary is only $100. They were closely followed by 13 hospitals in the Middle West of less than 25 beds whose average salary was only $106.



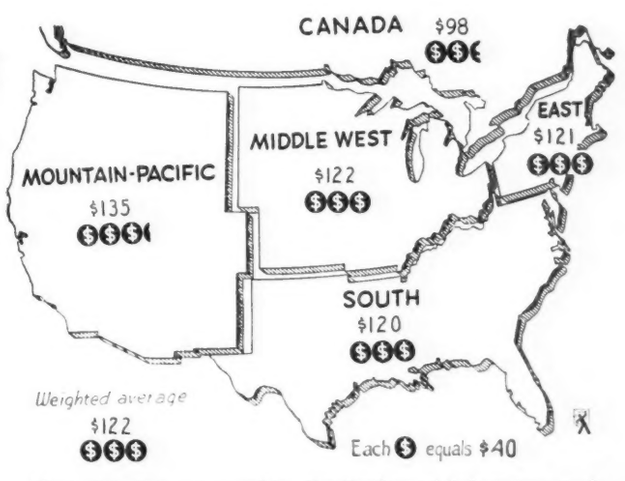
Salaries of x-ray technicians, on an average, rise in direct proportion to the size of hospital. Highest average salary reported in this group is $153 paid by nine institutions in the Mountain-Pacific area.

One hospital in the East and one in the South (each of them of from 100 to 199 beds) reported salaries of less than $60. At the other extreme were 25 hospitals, well scattered among all of the different areas, that paid their x-ray technicians $200 or more per month. (It is possible, of course, that some hospitals may have reported the salaries of radiologists here although the schedule clearly stated that the question referred to technicians.)

The Mountain and Pacific states are clearly the best region for x-ray technicians to obtain high salaries. In all sizes of hospitals except two, the Mountain and Pacific states lead the other areas in the salary paid to technicians and in these two size classes (from 50 to 99 beds and 500 beds and over) the Mountain and



Geographic distribution of x-ray technicians' salaries in the United States and Canada is shown on the map above.



Map showing geographic distribution of laboratory technicians' salaries. Total average salary reported is $122.

Pacific average is only $1 or $2 below the higher salary paid in the East. Canada and the Middle West are about tied for the low spot in average salaries, with the South also at about the same level. In the South the highest salary is paid in hospitals of from 100 to 199 beds and the salary in hospitals of 500 beds and over is about the same as in hospitals of less than 50 beds.

Apparently as the hospitals increase in size there are better supervision and more opportunity to use beginners and other technicians who will work for small salaries. The salary progression in Canada, also, is erratic and seems to have little or no relation to the size of hospital in which the technician works.

The salary pattern for laboratory technicians follows in considerable part the same form as that for x-ray technicians, except nearly always at a level a few dollars lower. This differential may be due to the greater hazard of radiologic work or to a longer period of training required for it.

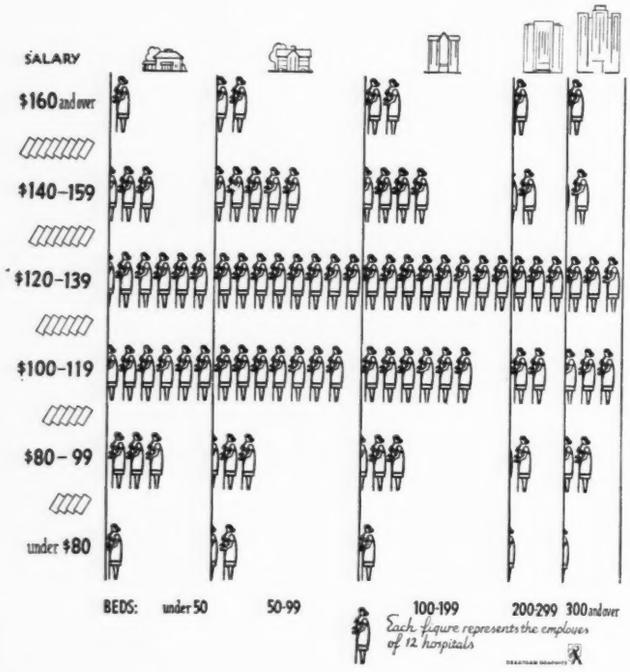
Of the 987 hospitals reporting figures on the salaries of laboratory technicians, three pay less than $50 per month, including the value of maintenance, and six pay $200 per month or more.

The highest salaries for laboratory technicians seem to be paid by the hospitals of from 100 to 300 beds, with the salary scale dropping off somewhat in both the larger and the smaller hospitals here represented.

Average Monthly Salaries of Laboratory Technicians

	Bed Capacities of Hospital							
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
East	$125*	$116	$124	$123	$120	$116	$119	$121
Middle West	106	123	121	122	123	122	128	122
South	100	114	123	125	131	110	105	120
Mountain-Pacific	127	130	127	141	143	148	147	135
Canada	115*	94	87	108	92	92	103	98
Total	$110	$119	$122	$124	$124	$118	$122	$122

*One report received



Salaries received by laboratory technicians vary from $50 to $200 per month. On an average, salaries paid this group are a few dollars lower than those paid x-ray technicians.

The Mountain and Pacific hospitals pay substantially higher salaries for laboratory technicians than any other region. The Middle West comes next and the South and the East follow.

The highest average salary for any one class is the $148 reported by nine hospitals of from 300 to 499 beds in the Mountain and Pacific states. Canadian salaries for this type of hospital employe are almost uniformly low, most of the institutions paying less than $100. In most of the hospitals in Canada the salaries seem to be about $30 to $50 smaller than those paid in hospitals of comparable size in the Mountain and Pacific states. These figures do not take account of the current difference in the exchange value of the Canadian and the U. S. dollars. While it is true that Canadian dollars are at a discount as compared with dollars of the United States, this fact probably has little practical influence on the everyday life and the purchasing power of the dollar except when it is used to buy imported products.

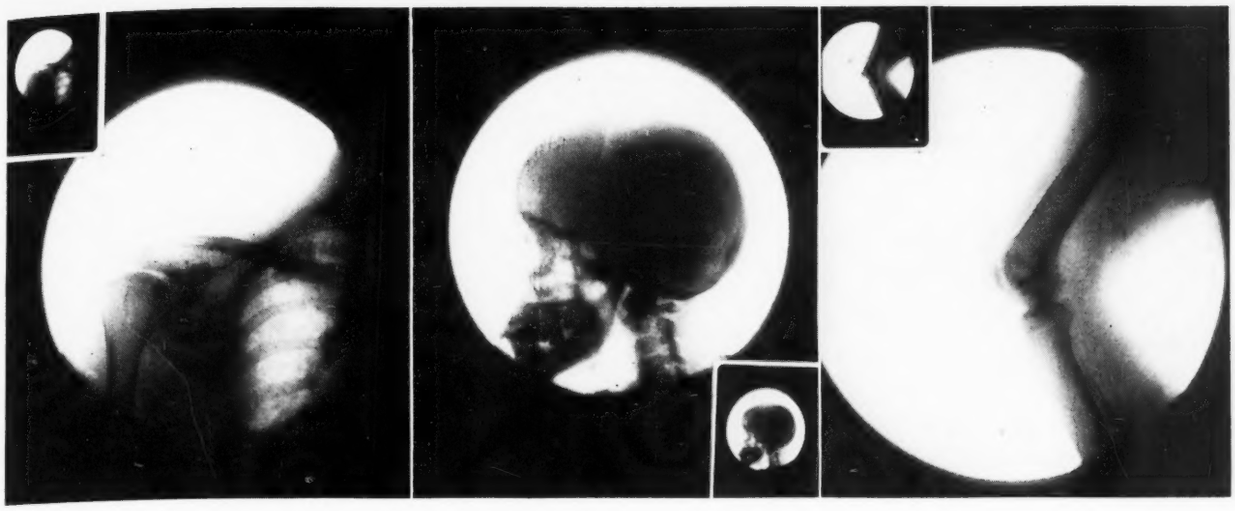
The schedules upon which this study is based were mailed on Dec. 9, 1940, and the returns were filled out during the remainder of that month and the first part of January 1941. Doubtless the demand of the United States Army for laboratory and x-ray technicians has served to increase somewhat the salaries paid to these workers in the ten or eleven months that have intervened since the schedules were filled out.

X-ray and laboratory technicians receive salaries that are about comparable with those of physical therapy technicians, occupational therapists and medical social service workers. Technicians' salaries are higher than those of chefs and laundry managers, except in the largest hospitals, and higher, in general, than those of record librarians.

Average Monthly Salaries of X-Ray Technicians

	Bed Capacities of Hospitals							
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
East	$110**	$125	$135	$132	$129	$128	$146	$132
Middle West	106	130	125	131	128	138	129	128
South	113	116	125	135	132	127	117	125
Mountain-Pacific	145**	132	134	144	143	153	144	139
Canada	115*	112	100	133	87	116	118	115
Total	$112	$125	$128	$133	$130	$132	$136	$129

*One report received **Two reports received



The Case for Fluorography

I. SETH HIRSCH, M.D.

Professor of Radiology, College of Medicine
New York University

FLUOROGRAPHY is an indirect radiographic method consisting of photography of the fluoroscopic image. The photographic reproduction has been made on various sized films, but the method here described utilizes a continuous film measuring 35 mm. in width, the actual size of the image being about 27 by 23 mm.

This fluorographic method is just now not intended as a complete substitute for the usual direct roentgenogram, though it seems to be developing in this direction. Generally speaking, it may be said that the fluorograph is superior to the direct visual observation of the evanescent fluorescent image not only because more detail may be observed on the film but also because it has the obvious advantage of furnishing a permanent record of the fluoroscopic image.

It is well known that changes in the lung can be visualized fluoroscopically only if they have a certain size and tests have shown that changes of small area can be seen on the fluorographic record that cannot be seen fluoroscopically. The 35 mm. fluorographic film does not show detail with the same sharpness and contrast as do the larger sized films used for regular radiographic work, but for a general gross survey with the view to determining whether or not pathological conditions exist, the 35 mm. film has numerous advantages over fluoroscopy and the regular film examination as will be shown. For the study of the detailed characteristics of the lesion, however, the large film is obviously the best record.

The paramount advantage of fluorography lies in the simplicity of the method and in the reduction in the cost of the examination, particularly in thoracic and gastro-intestinal work. Routine fluorography of every admission in a 100 bed hospital would cost less than $1 a day. The saving may be considered under four headings: (1) film, (2) developer, (3) filing space and (4) intensifying screen and cassettes.

Film: The section of 35 mm. film used for a chest examination costs but 2 per cent of the price of the regular film, which measures 14 by 17 inches.

Developer: The 12 ounces of developer used in the small developing tank will develop two lengths of 150 cm. film, in other words, 72 chest exposures, and one gallon of developer will develop about 720 fluorographic chest exposures, while less than 50 films, 14 by 17 inches, can be properly developed in this quantity of solution.

Filing Space: One thousand chest fluorographs can be filed in a wooden drawer at a negligible cost. This number of large films would require a two drawer cabinet of the usual size.

Intensifying Screen: The intensifying screens mounted in cassettes entail the additional procedure of loading and unloading. In the average laboratory, tons of metal are transported yearly to and from the dark room. Each cassette is handled nine times in the making of each roentgenogram. In a laboratory in which 10,000 chest films, 14 by 17 inches, are made each year, 88,400 pounds (more than 44 tons) of metal are transported yearly. The purchase and maintenance of cassettes and intensifying screens constitute a considerable yearly item in a large laboratory.

The low cost of fluorography makes possible the examination of large groups and permits survey of whole populations, an application of tremendous social value. It makes possible the routine examination of the chest and gastro-intestinal tracts of all patients admitted to the hospital, a routine which undoubtedly, will be introduced soon and will aid in the early diagnosis of many diseases of the lung, heart, mediastinum and gastro-intestinal tract. In hospitals in which from 30 to 40 per cent of admissions have an x-ray examination of the chest, not more than 10 per cent of the films show positive changes of value to the clinician. These pathologic cases, therefore, are discovered at an enormous

cost which fluorography, even when applied to 100 per cent of admissions, will reduce materially.

Fluorography of the bony system makes possible mass anatomic-anthropologic surveys as, for instance, in the study of ossification of the wrist bones, head forms and general habitus and its relationship to visceral morphology.

In recent years attempts have been made to examine for tuberculosis on a larger scale than ever before and every year millions of tuberculin tests are administered to isolate reactors. The analysis, however, is incomplete without an x-ray examination. It is now universally agreed that the roentgenologic examination is a far more accurate method of detecting early tuberculosis than the physical examination. It is this inability to examine large masses of individuals showing no clinical or laboratory evidence of disease that is responsible for the failure to diagnose many cases of tuberculosis in its minimal stage.

Fluoroscopy has been used extensively for tuberculosis surveys and, while inexpensive, is relatively inaccurate, gives no permanent record and is impractical in its application to the study of large groups because of the imposed limitation of 250 examinations per day by a single individual. On the other hand, 350 fluorograms can be read per hour.

Surveys have been made with special apparatus that utilizes paper films on rolls, but even this method is expensive and cumbersome and does not lend itself to general application and to the survey of large communities, though it is conceded that even this method is superior to fluoroscopy.

However, fluorographic surveys on 35 mm. films fill every diagnostic requirement, permitting the determination of the earliest lesions both in the lungs and in lymph nodes. The routine and methods of application are simple, rapid and practical and the cost is small.

In mobilization in Germany, Australia, Brazil, Argentina and other countries, the fluorographic method with 35 mm. films has been used extensively.*

In the lung, extensive infiltration by tuberculosis and carcinoma are often disclosed in accidental examinations and there is not a viscus in which unsuspected lesions, not only in the incipient but in the well-advanced stage, have not been discovered. It has, therefore, been made clearly evident that the body may harbor pathologic changes which do not by subjective and objective clinical evidence give any clue to their presence and which are disclosed only by the x-ray examination of the affected area.

This leads to the thought that a wider extension of the beneficent service would be eminently desirable, but the cost and complexity of the usual x-ray examination prevent the general extension of this service to whole populations. But for this there would then be no reason why x-ray surveys could not be made as universal as vaccination. At certain periods of life, an x-ray survey might be made of the bony system; at another, of the thorax, and at another, of the abdominal viscera. The wealth of medical and anthropologic information that would be thus disclosed is inestimable.

With the introduction of fluorography, which simplifies and materially reduces the cost of the examination, it becomes possible to think of the x-ray examination in universal terms.

Comparative Cost of Fluorographs and Roentgenographs per Thousand Hospital Examinations*

Item of Cost	*Fluorographs*	*Roentgenographs (Paper)*	*Roentgenographs (Film)*
Apparatus and Depreciation	$ 30	$ 30	$ 30
Films, Chemicals	46	374	574
Total	$ 76	$404	$604

*Disregarding cost of rent, labor, overhead and medical service.

*Cooper, E. R.: Brit. M. J. **2**: 245 (Aug. 24) 1940.

My First Hospital Convention

ONE meeting we went to at Atlantic City developed into what some people were describing later as a heated argument. A heated argument at a hospital convention, we found out, goes something like this: a mild mannered, soft spoken gentleman takes the floor, apologizes at length for his lack of complete information on the subject under discussion, hints that so-and-so might be his opinion, if he isn't mistaken, apologizes and sits down.

Another gentleman rises, as severe in his demeanor as a dove in the mating season. He begins by complimenting the parents of the first gentleman for having produced so intelligent, so wise, so able and so industrious a being as his eminent colleague. Through a haze of beautiful tributes, he begins to edge into the subject at hand and one gathers, finally, that there is a possibility that the second gentleman, personally, might disagree with the first gentleman, if the second gentleman isn't mistaken himself.

The first gentleman then returns all the compliments, hedges the shadow of his opinion with so many apologies that one might more easily disagree with an oyster and concludes with the observation that there must, of course, be two sides to every question. Try as we might, we couldn't find even one.

Faithful to an assignment which required that we report the meetings we attended for one of the hospital journals, we spent hours in our hotel room trying to make sense out of our own notes, which always appear to be the handiwork of a demented foreigner well in his cups. Between times, we discovered that the hotel charged 50 cents for a swim in the Atlantic Ocean, a fact which we remembered sharply when we saw a headline in the paper the day we got home. "U.S. to Defend Freedom of the Seas," this blazoned in bold letters.

They'd better get busy.—ROBERT M. CUNNINGHAM JR. *Reprinted from The Pilot, Evanston, Ill.*

For Efficiency—

Use Modern Business Forms

RONALD YAW

Director
Blodgett Memorial Hospital, Grand Rapids, Mich.

TODAY'S hospitals seem to be emerging from the twilight zone between an efficiently run business organization and a haphazardly operated charitable institution. Large numbers of hospitals have emerged and many others are emerging as the simple fact dawns upon them that, after all, modern business methods and scientific medicine are compatible.

Moreover, pressure for business methods directly or indirectly administered by business-minded trustees and others may be the catalyst that will make our present system of voluntary hospitals a strong and permanent one and that will discourage those who would destroy the present system or integrate it into another social order.

The number and variety of business forms in use in any industry today are staggering. Sales companies have beautiful order acknowledgments. Mills have order forms that are complete and accurate in every detail. Is there anything on earth more functional than the average restaurant check?

Hospitals are no exception to this rule. Our temperature charts are masterpieces, our input and output sheets, our labor records, our anesthesia sheets are perfect. However, businesses that succeed, be they steel mills or medical centers, sooner or later find that it pays them to pay attention to all of the forms in use and not to just a few vital ones.

We might apply the light of modern form design to hospital purchase orders, receiving reports, charge slips, checks (pay roll and general), ledgers, invoices, requisitions.

In order better to analyze our needs it might be well to go over some of the principal kinds of forms in use today, to consider their good points and their bad ones and to lay the yardstick of our particular needs across the confusing array of styles and kinds.

Unit Sets

Flat Forms: Ordinary printed pages, either padded or loose.

ADVANTAGES
Low initial cost

DISADVANTAGES
Very slow
High cost for handling
Difficult to build into a system

Fanfold Forms: These forms are continuous; as one is pulled out of the typewriter the next one goes in. They are made of a wide piece of paper, folded like a fan or a Z.

ADVANTAGES
Low price in high quantities (25,000 and up)
Side-tied construction keeps forms in registration
Different parts can be tinted or printed with colored inks for easy sorting
Fast operation; no time lost in jogging forms and handling carbon paper
Can be equipped with one-time carbon paper

DISADVANTAGES
Price prohibitive in small quantities
Moderately difficult to make erasures
One weight of paper must be used throughout
Special machine must be used
Machine not well adapted, usually, to other work

Continuous or Pack Forms: These forms are simply long strips of forms on top of one another. When one

Fanfold Forms

set is finished it is torn off and the next one advances into the machine. The principal problem, of course, is keeping them in registration. This is usually solved by putting a staple between sets of forms, by punching holes in the top of the form for ledger binding and using those holes as an aligning mechanism or by punching holes down the side of the forms and running them over gear teeth along the sides of the platen on the typewriter.

This type of business form is frequently precarboned with one-time carbon. Any of the methods of obtaining registration listed above are effective.

ADVANTAGES
Low cost in small quantity
Can use different weights of paper
Can use colored paper
Typing errors easily corrected
If one-time carbon is used, it can be reused in other departments

DISADVANTAGES
Must be "fed" to the typewriter with care
Although many mechanical contrivances are available to make a standard writing machine into a form writing machine, these are limited in scope either in number of copies or in efficiency
Not easy to shift typewriter to other kinds of work quickly

Unit Set Forms: This style of form is not continuous but is in single sets like the flat forms previously men-

tioned. These forms have one-time carbon paper interleaved; all pieces, including the carbon paper, are glued into a stub at the top, side or bottom. Usually the forms extend beyond the carbon paper on the end opposite the stub so that after the form is written the glued edge may be grasped in one hand and the extending edges of the form in the other. A quick snap pulls them apart.

ADVANTAGES

Easy to insert into typewriter
Any typewriter serves as a billing machine
Component parts of each form can vary in size, weight and color
Card stock can be used when desired
Information need not appear on all copies. By leaving the carbon paper out of certain portions, the information on the original does not appear on all the copies
One-time pencil carbon paper may be used
Unit sets are easy to build into a system. They can be so arranged that intentionally incomplete copies may be removed at any time during the typing of the form

DISADVANTAGES

Initial cost is higher than flat forms or continuous forms without one-time carbon paper
Typing errors not easily corrected
Each one must be fed into the typewriter separately (they can, however, be obtained preassembled on a common backpiece in continuous strips to eliminate this factor)
One-time carbon paper must be used and, being bound together, it cannot be readily reused elsewhere

The question of one-time carbon paper *versus* regular carbon paper is a question of where the emphasis is placed in the cost comparison. If the cost of the material is the deciding factor, then one-time carbon paper is a luxury. If the time cost is considered also, this may not be true. Several methods of economizing on carbon paper are possible.

Continuous Forms

DO

- Use your printing salesman's knowledge. He is a specialist. Other hospitals can give you ideas as to their methods of handling common problems. In many instances, your auditors will have worth-while suggestions on designing forms.
- Plan the form from the point of view of the person who has to type it and those who have to use it.
- Protect yourself by putting a clear statement on your purchase order of the conditions under which you are placing the order. If these conditions are printed on the back, a statement to the effect that these conditions are an integral part of the order should appear on the front.

DON'T

- Buy over one year's supply normally. Competitive form salesmen will get new ideas even if you don't.
- Clutter up your files with 20 pound paper. Use light weights on your file copies but don't expect your receiving clerk to be able to keep and handle a tissue sheet; use a good heavy one for him.
- Use up the top third of your internal copies by putting the name, address and telephone number of your institution on them. Your employes know where they work. Use this space for more essential entries.
- Scatter your horizontal stops all over. Put the name where the girl can stop in the same place for several other uses. She should be able to type any form with her left margin stop and two or three tabular stops; if she can't, your form has not been properly designed.
- Let your printer fill up the lower part of the form with his trademarks. Your form number is enough. Quantity and date are not essential.
- Forget that what you leave off the copy is sometimes as important as what you put on it. If your receiving clerk's copy of the purchase order is blank in the quantity column, he will have to count the syringes and weigh the beefsteak.

Pack Forms

1. If fanfold or pack forms are used, long strips of carbon paper are used. These are torn off a few inches at a time where the "name and address" spot usually receives the greatest wear.
2. These form writing machines can also be equipped with carbon paper in rolls, which may be more economical under certain conditions.
3. A heavy buffer sheet of carbon paper between the first and second copies will save a lot of wear on the other sheets of carbon paper.
4. One-time carbon paper can be reused several times in other departments.

A few general considerations are always in order on form usage. Who is going to use the form? How much use will each copy get? How many do you need? How many operations can you combine into one writing? Where should it be written? Don't pass over that last point too quickly. Many times you can find someone who has to write that information anyway and you can tack a few additional copies to this form which may very well serve another department or two.

Some hospitals eliminate the use of carbon paper entirely by use of a gelatin type of duplicator or by a "liquid" type of duplicator.

There are two perils to consider in the design of any system. One is to have a system so complex that it takes more people to "work the system" than it does to do the work. The other is to economize on forms to the extent that expensive time is used doing menial work.

If a Patient Attempts Suicide

MAXWELL S. FRANK, M.D.

Assistant Director, Mount Sinai Hospial, New York City

DEPRESSION, a feeling of futility and fear for the future frequently accompany many illnesses. Under such circumstances, a hopeless outlook, accompanied by attempts at suicide, is not an unexpected sequel. Every hospital administrator has experienced the unpleasant consequences of suicides of hospitalized patients—publicity, endless inquiries from newspapers and the accusations of distraught relatives.

However desirable it may be for the general hospital to include among its facilities provisions for the care of such cases, most of these hospitals are not organized to cope with the problem of the frankly psychotic patient. Therefore, they usually refer such patients to the nearest governmental institution that is equipped with facilities for their treatment.

Tendencies toward psychiatric behavior, however, frequently develop subsequent to admission to a hospital, creating for the administration the problem of protecting other patients from the disturbing patient as well as of preventing him from self-inflicted injury.

The methods of meeting this problem are essentially the same in the private pavilion and in the wards of Mount Sinai Hospital, New York. In the private pavilion, the patient who threatens suicide or otherwise becomes disturbing is at once reported to the floor supervisor, who immediately notifies an assistant director. The latter, after investigation, communicates with the private physician and requests him to make arrangements for the prompt removal of his patient. If too ill for such transfer, the patient is taken to a so-called "quiet room" on the ground floor, especially equipped for the special care required. The use of this room is temporary, until arrangements can be completed for transfer to another institution or until the patient is well enough to be moved. Twenty-four hour special nursing is required while the patient is in the quiet room.

On the wards, patients who develop psychotic or suicidal tendencies receive the attention of an organized psychiatric service. Posted in each ward and included in the house staff rules and regulations is the following outline of procedure.

"1. The ward nurse shall immediately notify the intern or resident in charge of the service and the supervisor of nurses.

"2. The nursing supervisor shall immediately notify the assistant director on duty.

"3. The intern or resident in charge of the service shall visit the patient at once to decide, primarily, upon the physical competence of the patient to carry out his threats. If the patient is actively suicidal or otherwise disturbed, the resident or intern shall notify the assistant director, who will arrange for the transfer of the patient to the reception ward on the ground floor, where the resident or assistant resident in neurology will be asked to examine the patient.

For most administrators the handling of patients who develop psychotic tendencies is a worrisome problem. Doctor Frank describes satisfactory procedures adopted at Mount Sinai Hospital for dealing with these cases

"If the patient is physically unable to carry out his threats, the resident or assistant resident in neurology shall be called to the ward to examine the patient. Except under unusual circumstances, members of the house staff shall not administer sedatives prior to the psychiatric consultation, thus avoiding the possibility of obscuring the psychiatric picture and making any consultation valueless for several hours.

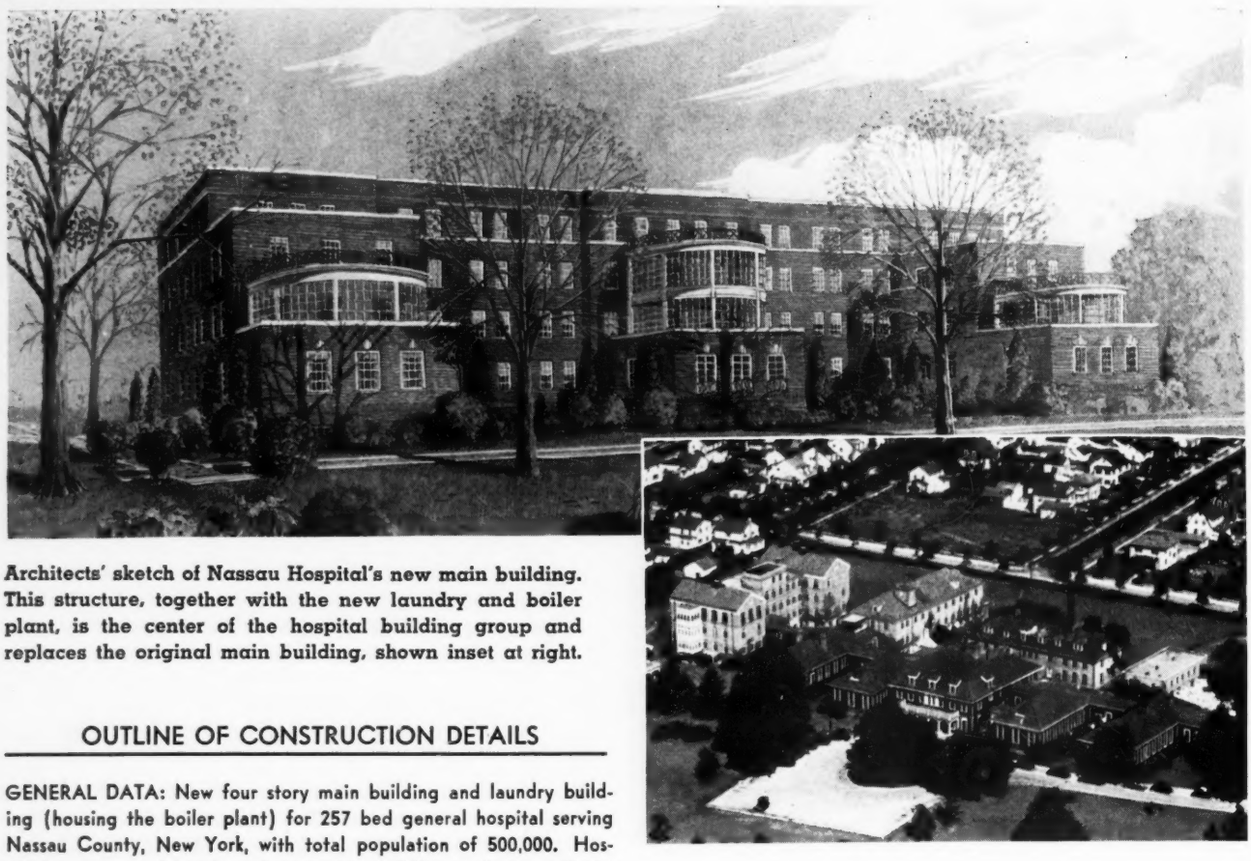
"4. The resident or assistant resident in neurology, after his examination, shall either call at once for an emergency psychiatric consultation by a member of the attending staff or, in case of doubt, shall telephone to the attending psychiatrist on duty to discuss the situation and to reach a decision as to whether an immediate consultation by an attending psychiatrist can safely be deferred and whether sedatives may be administered.

"5. If a decision is reached by the attending neurologist to transfer a patient to a hospital for psychiatric patients, the assistant director shall be notified so that he may make the necessary arrangements. Pending the transfer, an orderly or nurse shall be assigned by the nursing supervisor to remain with the patient until the ambulance arrives. An abstract of the patient's history shall be prepared by the intern or resident before the patient is removed from the hospital.

"The family of the patient shall be notified before transfer by the social service department during the day and by the admitting office after 5 p.m. No patient shall be transferred without the knowledge and consent of his family, since the family's decision in the matter must be honored.

"6. If the patient is not actively suicidal, as indicated in the note on the progress sheet written by the resident in neurology, the intern or resident in charge of the service shall immediately post the patient for psychiatric consultation. If an urgent situation arises in the morning that cannot wait for the arrival of a consultant in the afternoon, one of the acting chiefs of the clinic in the outpatient department shall be called."

Adherence to the foregoing procedure enables the nursing staff, house staff, attending staff and administration properly to participate in the care and final disposition of these patients.



Architects' sketch of Nassau Hospital's new main building. This structure, together with the new laundry and boiler plant, is the center of the hospital building group and replaces the original main building, shown inset at right.

Nassau's New Main Building and Power Plant

CROSS and CROSS
Architects
New York City

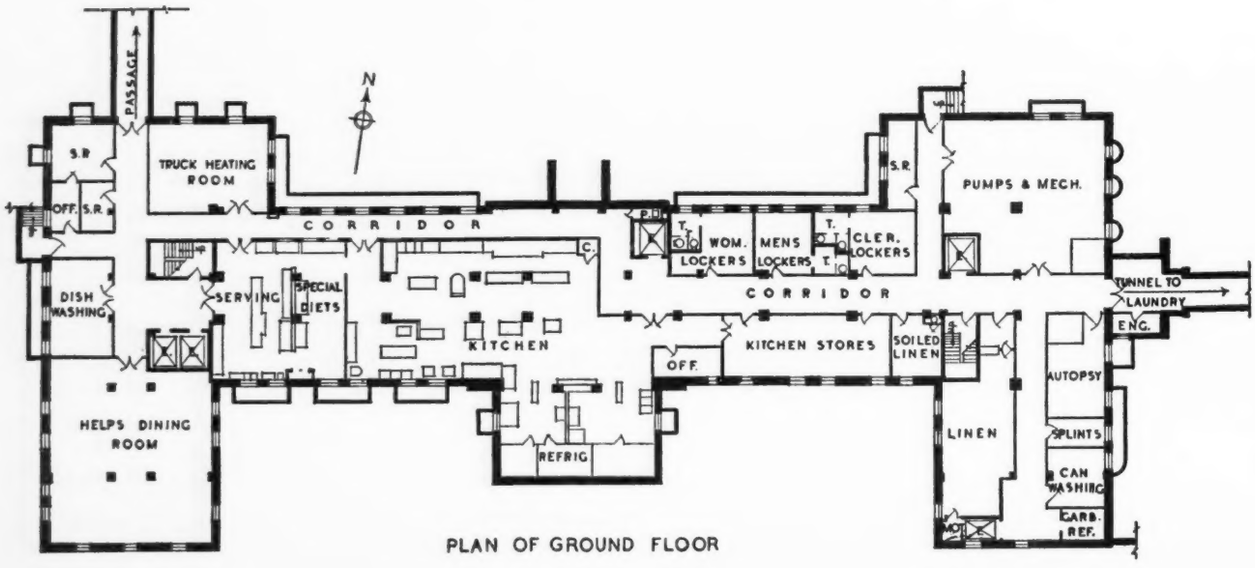
GEORGE L. DAVIS
Superintendent
Nassau Hospital, Mineola, N. Y.

OUTLINE OF CONSTRUCTION DETAILS

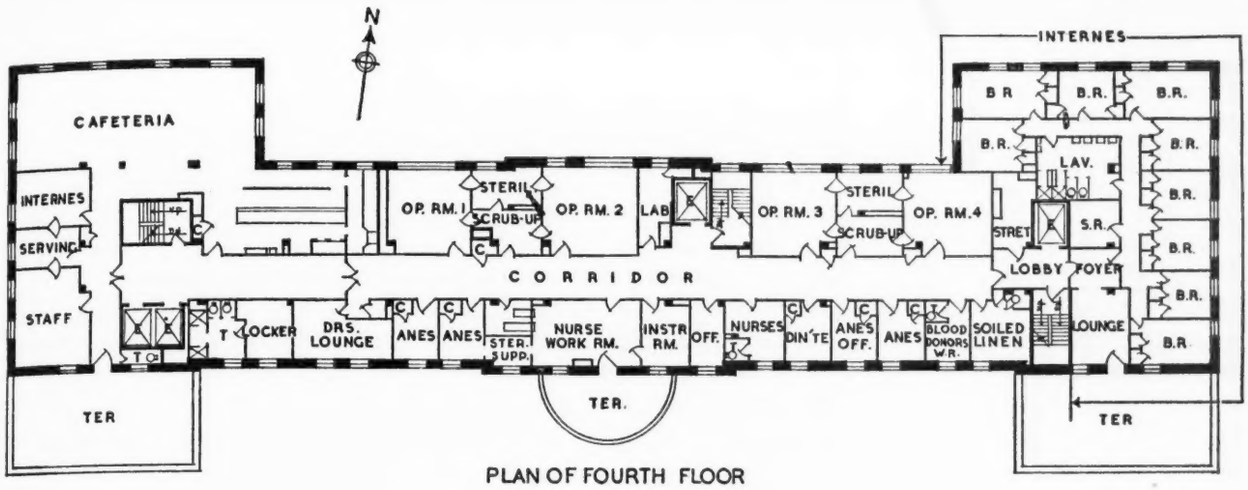
GENERAL DATA: New four story main building and laundry building (housing the boiler plant) for 257 bed general hospital serving Nassau County, New York, with total population of 500,000. Hospital group consists also of maternity building, private patients' pavilion, nurses' home, superintendent's cottage and cottages for clerical staff, auditorium and garage. Original main building has been demolished. New main building connects with maternity and private patients' buildings by basement and one story covered passageway. Laundry building connects with main building by underground passageway.

MAIN BUILDING

CONSTRUCTION: Frame, floor and roof arches, reenforced concrete; exterior walls, brick with limestone sills, copings and band course. Partitions, terra cotta and gypsum block. Windows, double hung pivoted steel casement and projected sash; operating and emergency treatment rooms, glass block. Doors, wood, kalamein and



PLAN OF GROUND FLOOR



PLAN OF FOURTH FLOOR

hollow metal with steel frames; entrance doors, bronze. Stairs, steel with cement treads and platforms.

WALLS AND CEILINGS: Operating, emergency treatment, scrub-up and sterilizing rooms, ceramic glazed tile. Main kitchen and dishwashing room, glazed structural tile. Elsewhere, plaster. Corridors, utility room and diet kitchens, acoustical plaster on ceilings. Cafeteria, main kitchen, dishwashing room and help's dining room, pan type of acoustical treatment.

FLOORS: Wards, private and semiprivate rooms, cafeteria, corridors, waiting rooms, offices and solariums, asphalt tile. Main lobby, rubber tile. Main kitchen, quarry tile. Operating, emergency treatment, anesthesia, scrub-up and sterilizing rooms, terrazzo, with connecting grid in first three. Nurses' workroom, utility rooms of operating suite and toilets, tile; also tile wainscot.

LIGHTING: Indirect, except in operating and emergency treatment rooms and service rooms. Operating rooms, corridors and stairs, emergency auxiliary lighting plant of 10 kw. capacity.

HEATING: Low pressure vacuum system, with separate system for operating and anesthesia rooms. Radiators, hospital type, wall hung. Main kitchen, sterilizers and laboratory, high pressure steam.

VENTILATION: Main kitchen, filtered fresh air supply. Operating, emergency treatment and anesthesia rooms, unit heaters. Toilets, laboratory fumehood, workroom and clothes room, exhaust ventilation.

AIR CONDITIONING: Operating and emergency treatment rooms only.

ELEVATORS: Four automatic self-leveling push button with speed of 125 feet per minute.

CALL SYSTEMS: Doctors' register, doctors' paging, nurses' call.

LAUNDRY BUILDING AND BOILER PLANT

CONSTRUCTION: Frame, fireproof structural steel with concrete floor and roof arches. Walls, brick. Partitions, cinder block and terra cotta tile.

WALLS: Laundry, entrance lobby and mending room, architectural glazed terra cotta wainscot, 10 feet high, with plaster above. Boiler room and basement corridors, semivitrified brick.

FLOORS: Laundry, entrance lobby and mending room, quarry tile. Boiler room and basement corridors, cement. Toilets, tile.

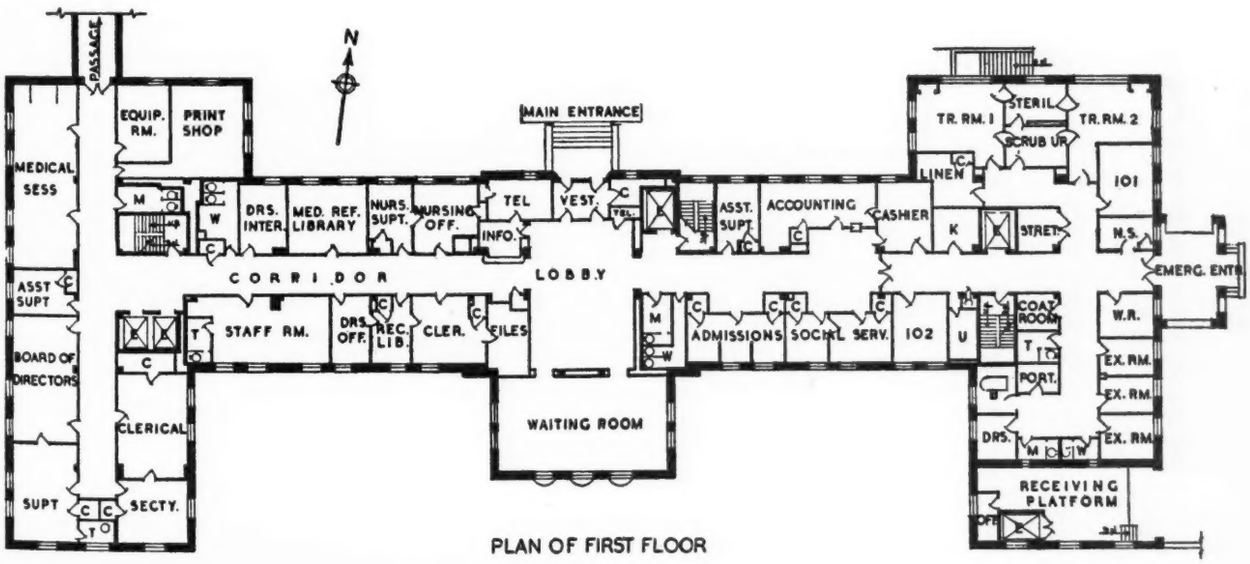
HEATING AND VENTILATING: Filtered fresh air supply and unit heaters. Exhaust ventilation.

LAUNDRY EQUIPMENT: Three washers, two extractors, large extractor with monorail and cranes, flatwork ironer, drying tumbler, four presses, shake-out tubs.

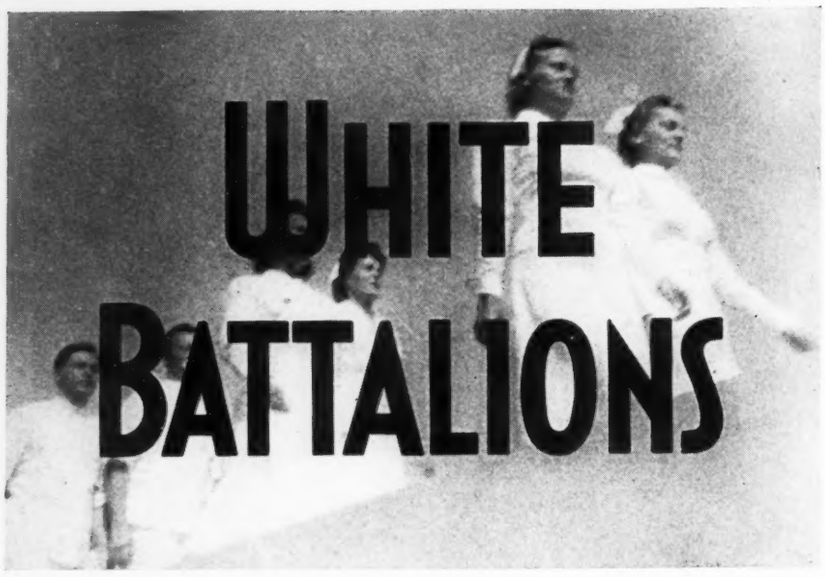
BOILER ROOM EQUIPMENT: Two high pressure 200 h.p. oil burning boilers, hot water storage, pumps.

REFRIGERATION: Central plant, ammonia system, 25 ton capacity.

COSTS: Total cost of buildings and equipment, $794,741. Cost per cubic foot without equipment, 53 cents. Cost per cublic foot with equipment, 61.5 cents.



PLAN OF FIRST FLOOR



ARMIES march across the screen in the opening scenes of the new sound motion picture sponsored by the American College of Surgeons, but they are armies of mercy, "White Battalions—Serving All Mankind."

The fortresses from which these soldiers hold back the enemies, death, disease and disablement, are hospitals. The people whom they defend are the patients. Back of the armies of mercy, providing them with the means to maintain the forts and to buy the armament for the battle against disease, are people who serve by giving, some of them moved to do so by gratitude for their own lives or those of loved ones prolonged and made happier by the kind of victory that the fighters in modern hospitals delight to win.

Several hospitals helped in the making of this picture. The opening sequences, which show scenes of a symbolic nature to establish the mood, were photographed at Evanston Hospital, Evanston, Ill. Passavant Memorial Hospital, Chicago, furnished the setting for the emergency department scenes at the beginning of the picture. Other Chicago hospitals that furnished scenes and personnel for the "tour of the hospital" were Children's Memorial, St. Luke's and St. Joseph's. The closing scene is the front entrance of Billings Memorial Hospital; Illinois Masonic Hospital and Ravenswood Hospital furnished equipment and supplies. Several manufacturers and dealers also contributed equipment, furnishings and materials for the studio setups.

A cast of professional motion picture artists was carefully selected for the leading parts in this drama of hospital service. An ideal atmospheric background has been purposefully built to illustrate, for the benefit of hospital people, the effect of considerate manner and sympathetic tones of voice upon the morale of the patient and family. At the same time an impression is conveyed to the public of the individualized treatment that patients receive in our modern approved hospitals. The reference to the Blue Cross service plans indicates their value to the public.

Patsy, a rich little girl, and Michael, a poor little boy, are the living, lovable objects upon which the hospital demonstrates its effectiveness. An automobile crash on the way home from a party brings Patsy there; infantile paralysis is responsible for Michael's presence. Both are tragedies that can send anybody's children to the hospital tonight, tomorrow, next week or next year.

The audience identifies itself with the anxious parents and through their eyes views the massing of forces to restore Patsy and Michael to normal unimpaired vigor and with them rejoices in the outcome.

When Patsy's father asks, "Isn't there something we can do to assure every poor child the same care Patsy got?" and the doctor and administrator, in reply, take the parents on a tour of the hospital to show what is being done and how an unrestricted endowment would help most, there is developed understanding of the integrated functioning of the standardized hospital and what that means for the patient.

Premières of the film, which was produced under the supervision of Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, with associate consultants and which was made possible through a grant from the Becton Dickinson Foundation for the Extension of Scientific Knowledge, will be held this month in theaters, hospitals and public auditoriums in a number of cities. The opening première will be held in Boston during the Clinical Congress of the American College of Surgeons, November 4. The picture is on 16 or 35 millimeter film, is two reels in length and takes about twenty-five minutes for showing.

"White Battalions" will be available through the American College of Surgeons at no expense other than carrying charges. Both large and neighborhood motion picture theaters are expected to utilize it as an educational feature.

Supervision in Clinical Nursing

EDNA S. NEWMAN, R.N.

Assistant Professor of Nursing Education
University of Chicago

THE literal meaning of the term "to supervise" is to oversee. Originally, supervision was limited to directing the worker and to inspecting his work. Essentially, this still is the fundamental concept. However, changes in the relationship between employe and employer have resulted in transforming the functions of supervision to harmonize with the democratic society in which it operates.

Supervision in clinical nursing is based on the content of the technics, philosophy and psychology peculiar to nursing. These are subject to adjustment and modification, as they are influenced by contacts with changing social problems, enlarging fields of service and new developments in related biological, physical and social sciences.

For the purpose of clarification some definition of the terms used in this article may be helpful. The term "supervisory unit" is herein applied to any clinical division the nursing activities of which are complex enough to require the direction of a nurse executive called a "supervisor." This officer is employed by and responsible to the director of the nursing department and has one or more assistants, called assistant supervisors or head nurses. The practices obtaining on the supervisory unit are a manifestation of the purposes, policies and the spirit of the hospital.

For example, in a hospital that assumes as one of its functions medical and other types of professional education, the supervisor understands that a considerable portion of the time and energy of the nursing staff must be devoted to assisting the attending medical staff in conducting bedside teaching and clinics. It is her responsibility to interpret to her staff how and why it may aid and cooperate in promoting such teaching activities.

If it is a hospital policy to encourage and carry on clinical research, the supervisor's attitude and teaching are reflected in the intelligent observation and accurate recording of symptoms and results.

A clinical division may vary greatly in individual situations. Whether it consists of a number of undifferentiated services or follows lines of strict segregation and classification, its activities must revolve about common basic elements. These are: (1) patients and personnel, (2) physical facilities, (3) time and (4) control.

In the hospital nursing department, the officers administering nursing service and the school, the classroom and ward instructors are all engaged to some extent in supervision.

With the nursing profession affected so vitally by the present emergency situation, supervision takes on added significance. This article is a scholarly interpretation of the subject in the light of current developments

The supervisor may be an administrator who has charge of the entire nursing service at night or a general administrative officer who is the assistant to the director of the nursing department. On the other hand, the duties and responsibilities of the so-called supervisor may be strictly those of a head nurse. Nursing needs to clear up this confusion by some standardization in its nomenclature.

Whatever the specific title, responsibilities and position of the person engaged in supervision the basic principles are not altered. Inherent in nursing supervision is its chief duty of directing and coordinating nursing activities in one or more of the hospital's clinical units.

While essentially administrative, supervision must be permeated with the spirit and substance of education. Administration and education depend upon and supplement each other, achieving, thereby, a stronger and more perfect fusion. These parallel processes are carried on in the clinical division. The activities of the division, in which supervision is one of the collaborating agencies, focus upon the care of the patient, the provision of favorable physical, social and spiritual environment, the education of personnel, patients and community, and the promotion of satisfactory professional and personal relationships.

The supervisory process consists of several functions. It must include planning the most effective and economical use of resources, effort and facilities in relation to the time, staff and materials at its disposal.

Supervision contributes direction and guidance to execution of these plans. It involves expert technical knowledge, giving personal instruction and demonstrating superior methods. The results should be improvement of the skills, understandings and attitudes of the worker. This function of supervision involves the organization of training programs over specified periods of time to stimulate initiative, self-reliance, resourcefulness and the creative ability of the worker. It is here that the educational aspects of supervision are paramount but are so closely interrelated with administrative aspects that lines of division are imperceptible. Each depends upon the other for fulfillment.

If it is to discover faults, correct weaknesses and institute improved performance, supervision must depend upon information-gathering devices, such as personal visits, inspections and conferences with individuals and groups. In this way it not only acquires knowledge by observation and avails itself of valuable contributions made by co-workers but is

enabled to transmit pertinent information to others. Equally important to the administrative functioning of supervision are official and informal reports and records. These essentials to teaching and guidance form the basis for evaluating performance and constructing future policies. In personnel administration they constitute a phase of first importance.

It is a limited program of supervision that has only the immediate aims of training the worker and of improving production. When guidance is accepted as part of the ultimate aim of supervision, the supervisor is interested in more than the accumulation of appraisal records of the nursing staff. Teaching the head nurse how to make significant observations, how to evaluate her staff objectively and how to improve the form and content of personnel records contribute to her own development. The record is then discussed with the individual worker and serves as a basis for personal counseling and guidance.

The tendency to become routinized, to be overwhelmed by the multitude of details performed in a mechanical, unthinking fashion can be overcome by broader perspective. Supervision has the function of coordinating the activities of the unit and the authority to administer these activities so that staff, materials and work schedules can be adjusted to the needs and purposes of the unit. It means that the supervisor as an expert in her clinical specialty has a comprehensive grasp of the subject matter in the field. She takes advantage of all teaching opportunities presented and organizes the material into a coordinated program of ward instruction. Coordination also enters into the part played by the division as a center for teaching health to patients and, indirectly, to the community. Where nursing service is the primary concern, opportunities for research are limited by lack of trained workers and facilities. However, supervision has the responsibility for developing an awareness of needs and for suggesting ways of meeting them. Advancement and progress are stimulated by attitudes of self-criticism and flexibility and by willingness to experiment with newer and better methods and practices.

The criteria for judging the success of a supervisory program rest on the effectiveness with which principles of supervision are applied in concrete situations. Objective devices for measuring human qualities have not been perfected, but evidence of satisfactory personal relationships is found in the existence of high morale and lack of friction.

Red Cross Expands Aid Corps

V. K. LIBBY

American Red Cross

AS AN emergency measure for preparedness, Mayor F. H. La Guardia, director of civilian defense, has called for 100,000 women as volunteers to be trained as a nurses' aid corps by the American Red Cross. All arrangements for enrolling, training and placing the aids will be made through the 3730 local Red Cross chapters working in collaboration with the Office of Civilian Defense.

These aids will be just what their name indicates—women especially selected and trained to serve as assistants to graduate nurses in hospitals, clinics or wherever they may be needed. They will always be under the supervision of a graduate nurse and will supplement, but never supplant, the paid workers. By performing a variety of necessary routine duties, they will leave the professional nurse free to carry on work which can be undertaken only by an experienced graduate.

Mary Beard, director of the American Red Cross Nursing Service, has emphasized that while such a nurses' aid corps is distinctly a volunteer activity, it is also a nursing activity and must maintain standards and discipline that will meet with the approval of the nursing profession.

Not all the women who may present themselves for this specialized training will be eligible. Each volunteer who is enrolled will be selected after a personal interview by a representative of the local Red Cross chapter's nurses' aid committee, the members of which are drawn from local hospital, public health and nursing groups. A successful applicant must be between the ages of 18 and 50, must have high school education or its equivalent and must be able to qualify physically. She must serve without remuneration and, after satisfactorily completing the American Red Cross intensive 80 hours' training course, must give a minimum of 150 hours' yearly service. The first 150 hours of service after completion of the course must be spent on hospital wards, after which assignment may be made to public health and other organizations.

The course provides 80 hours of intensive instruction in a period of about seven weeks, with classes limited to 30 aids.

The first half of this training course is given by a graduate nurse in the local Red Cross chapter house in collaboration with local hospitals and nursing organizations. This constitutes the probationary period and requires two hours of instruction daily on five days a week for four weeks. The second half of the course consists of supervised practice in a hospital designated as a training center by the Office of Civilian Defense and the Red Cross. Hospitals used for this purpose must be on the approved list of the American College of Surgeons and must be registered by the American Medical Association. The American Red Cross assists the hospital to provide competent instructors and nursing supervisors for the course.

Those who complete the course will be enrolled in the volunteer nurses' aid corps of the American Red Cross with the assurance that they will play an important rôle in civilian defense, but they will retain their membership in the corps only as long as they continue to render adequate service of at least 150 hours yearly during the time of national emergency.

The American Red Cross and the Office of Civilian Defense are providing for this service by arrangement with local hospitals and field nursing agencies.

Small Orders Mean High Costs

CORA GOULD

Superintendent, Children's Country Home
Westfield, N. J.

IN REGARD to purchasing, the small hospital is definitely handicapped. Usually, this is because the superintendent is a practitioner of all trades and he or she does not have the proper amount of time to devote to the details involved in good purchasing. The small hospital is frequently short of proper storage space. In many instances it is handicapped financially.

There is a great deal we in small hospitals can do to help the hospital financially and also to save ourselves work and detail if a few moments' thought is given to each order we write. Few of us realize the cost to the manufacturer or dealer in handling small orders, especially those under $15 in value. Their costs are reflected in our costs. One manufacturer of supplies used a great deal by hospitals tells us that the cost of handling orders under $15 is $2.50 per order. The standardized procedure in nearly all of the larger companies involves the following steps:

1. The order is received in the mailing department and sorted for distribution.
2. It is received in the order registry department for recording, where it is copied off or pasted on the manufacturer's standard order form.
3. It is received in the inventory department and the items are deducted from perpetual inventory records.
4. It is received in the pricing department for the insertion of prices and the extension of totals.
5. It is received in the traffic department for transportation routing.
6. It is received in the shipping department office for sorting into freight, truck, express or parcel post routings.
7. It is dispatched from shipping department office to shipping clerks for assembly, inspection check, packing, weighing and delivery to outgoing transportation.
8. It is received in invoice department for billing.
9. It is received in statistical department for sales analysis statistics.
10. It is received in filing department for final handling.

There is another cost to be considered, that of the shipping charges. Many suppliers will pay the delivery cost on orders of $50 or more. On all small orders the hospital pays those charges.

Do you know the procedure that takes place right in your own hospital in the handling of orders, whether your hospital is small or large? Figure out what this phase of purchasing costs you. With each order is involved: your time; the order blank itself; the postage and clerical work of sending the order out to the supplier; checking the material when you receive it; putting it on the shelf; checking invoices against the order; filing the completed orders, and payment of the bill, involving checks, more postage and probably the signature of one or more members of your board.

With the elimination of small orders, hospital purchasing is facilitated, releasing, simultaneously, a considerable amount of administrative time and relieving the office personnel of repetitious routine

Pick up any drug catalog, for instance, and order 100 tablets in common use. Glance a little further on the list and you find that 500 of these tablets can be purchased at one half or one third of the cost per tablet on the smaller quantity. If 100 tablets supplies your hospital adequately for two or three weeks or even a month, 500 is not too many to buy at one time, provided they are of standard use. Think of the steps you will be saving yourself and your hospital as well as the manufacturer.

It is not only the small hospital that is negligent or guilty but all hospitals may well check up on themselves in this regard. One large institution learned that it had sent out 2500 orders of less than $5 each in a one year period. Why not check all bills and orders for a period of one year and ascertain just how many small items can be eliminated in the future? A six months' supply of staple or standard items is not too much to carry, particularly under present conditions. Unless too much financial value is involved, a six months' supply is never too much for any hospital to have on hand if proper storage facilities are available. Market conditions may cause this statement to vary a little from time to time.

Inventory values may easily be any amount up to your expenses for supplies for a three month period. If your supplies cost $500 a month, you can well afford to carry an inventory of $1500. This should give you a complete financial turnover of stock every three months. Of course, some of the items may be on hand a year, some for only a month. Previous experience must guide your judgment.

Groceries may easily be ordered on a monthly basis. You soon learn the quantities necessary for the thirty day period and then no shortage of food occurs during this interval. Send the list with specifications to several wholesale grocery houses for quotations, check the lists when they return to your office and note the savings. The entire procedure may take an hour or so of your time once each month but it is then out of the way and off your mind for another four weeks.

Regardless of the size of hospital or institution, it is well worth the time and money to have a requisition system for supplies and to make it mandatory that the requisitions clear through one person's hands, preferably the person who is doing the buying. In almost all instances, in hospitals of 100 beds or less, this person should be the superintendent.

The keeping of a purchase record is invaluable. A plain 3 inch by 5

inch index card indicating the article purchased, from whom purchased, the quantity, date and the cost is adequate. If the information thus gained is used properly, the purchase record is a money saver. This system is also a check on mistaken charges that sometimes appear on invoices.

If your hospital has proper storage space and only a part-time stores clerk, it is an easy matter to set up minimum quantity figures and have the stock checked once a month or once every two months. Check all requisitions periodically especially now during the national emergency. Ascertain whether or not additional items should be placed in your standard stock. If so, this will eliminate at least a little of the unavoidable emergency buying, some of which will always exist in hospitals because of the nature of their work.

Hospitals will have to increase their stocks in view of this emergency period so as not to be handicapped for supplies; perhaps, through this experience we shall learn to be more careful in our buying methods. It is worth while to look over all available storage space and to make the necessary changes in order to handle this phase of management more efficiently and to the greater satisfaction and cooperation of both hospital and suppliers.

A Plea for Cost Accounting

A. H. CROSS
Administrator, Jewish Hospital, Louisville, Ky.

ONE of the problems confronting the hospital administrator today is to provide for accurate and adequate records and statistics. Too many administrators, when the subject of accounting is mentioned, mentally throw up their hands in despair. However, a knowledge of accounting is as essential to a hospital administrator as is his ability to speak English. The administrator must be able to discuss finances and financial problems with his trustees, auditors and the public.

Hospital accounting records and procedures are the camera by which is recorded the financial picture of the institution at any given date or the results of operations over a period of time. In the last analysis, accounting records are merely records of human relationship and activities, expressed in financial terms. With these records the administrator can more ably control his institution and is able to interpret his results.

How can an administrator determine whether or not he can add a new department or expand old ones unless he has a knowledge of his possible income and expense? How can he determine whether he can replace old equipment, buy new furniture, increase personnel or pay more wages unless he has adequate records? How does he know his room rates and charges for special services will cover overhead unless he keeps records and is able to read the reports?

How can the hospital head know how much the income is per patient per day or how much it costs per day to care for patients? How does the income or cost compare with that of other institutions of similar size? Is he properly controlling expenditures for labor and supplies? Are patients being charged for all services rendered?

These and many other questions occur daily with a properly managed institution. It is by means of accounting records that such questions may be answered.

How does the administrator know the efficiency of the kitchen unless he knows the average cost per meal served? Does this cost fluctuate or does it follow a seasonal or a cost of living curve? Should there be fluctuations? If this cost exceeds that of other similar institutions then the administrator must locate and correct the variation to arrive at the minimum cost commensurate with good service.

What are the linen costs for his institution? Are linens worn out or carried out? How do they withstand wear from laundry? How are the laundry costs? Does he have a good laundry operator or does he have a good talker?

How efficient is the engineer? Does he waste coal or does he use it? Is the equipment maintained properly or is it being replaced unnecessarily? Is the equipment functioning or is it out of order?

What does it cost for professional supplies to care for each patient? Is the patient charged for all chargeable items or is it too much trouble?

To control costs properly requires efficient cost accounting without which we are handicapping our success and the success of our hospitals.

It would seem from this discussion that only an accountant could manage a hospital. Such is not the case. It is up to the administrator to have a working knowledge of hospital financial reports and understand how to interpret them. The type of records kept by the accounting department should be in conformity with accepted standards. Only by standardized accounting practice may the greatest results be obtained from comparative statements.

By comparing his reports against previous reports and by comparing with available reports from other institutions, the hospital administrator will detect inefficiencies of departments or lack of conservation of supplies.

Comparative hospital statements may be had of costs per patient day, cost per meal served, cost per pound of laundry, cost of professional supplies for each patient, cost of nursing service and other standard services. However, unless records for comparison have been kept along standardized procedures, their value decreases.

For example, standard accounting practice recommends a dietary department expense to which are chargeable all amounts incurred in feeding patients and personnel. In some instances meals for personnel of the various departments are charged to those departments and credit is given the dietary department. Another example would be to try to allocate utilities to various departments instead of charging them to the department of plant operation. It can be seen that comparative expense information between departments of these two types of accounting would lose its value because of the difference in procedure.

If the greatest benefit is to be obtained from cost accounting, it must be kept up to date in order to take immediate steps for correcting variations.

Check List of Laboratory Tests

ALEXANDER O. GETTLER, Ph.D

Department of Hospitals, New York City

WHAT chemical tests should a well-equipped hospital laboratory be ready to perform accurately and at a moment's notice? The following list will answer this question for you. The most valuable of the many tests available have been included and the conditions in which they will prove diagnostically helpful have been noted.

Because of space limitations, methods for the detection and quantitative estimation of the more common poisons have been omitted.

Blood: Serum or Plasma: Quantitative

(Numerals following name of each test refer to systems and conditions shown in accompanying list of diagnostic tests)

Alkaline reserve	1, 2, 4, 6, 7, 9
Amino-acid nitrogen	1, 2, 5, 8
Ammonia nitrogen	1, 2, 11
Amylase (diastatic activity)	2
Ascorbic acid	5
Bromide	3
Bromsulphthalein liver function test	5
Calcium	1, 7, 10, 13
Carbon dioxide tension	1, 2, 7, 9
Chloride	1, 2, 7, 8, 9, 10, 11
Cholesterol (total and free)	1, 2, 5, 7, 8, 10
Congo red	1, 5, 10
Creatinine	1
Dextrose (glucose) tolerance	2, 7, 10
Diazo	1
Glutathione	2, 9, 10
Icteric index	1, 3, 5, 6, 8, 11
Iodine	10
Lactic acid	2, 7, 10
Lipide phosphorus (lecithin)	1, 2, 7, 8
Methemoglobin	8, 11
Nonprotein nitrogen	1, 2, 7, 11
Oxygen capacity	8, 9, 11
Oxygen content	8, 9, 11
Phenols (free)	1, 6, 8
Phosphatase	2, 5, 7, 8, 10, 12
Phosphates (inorganic)	1, 7, 10, 13
Potassium	1, 2, 10
Proteins (albumin, globulin, fibrinogen partition)	1, 5, 9
Reducing action (glucose)	1, 2, 3, 7, 10
Sodium	1, 2, 10
Sulfanilamide, sulfapyridine and acetyl sulfapyridine	14
Urea clearance	1, 7
Urea nitrogen	1, 2, 6, 7, 10, 11
Uric acid	1, 2, 7, 8
van den Bergh	1, 5, 6, 8, 11

KEY TO DIAGNOSTIC TESTS

1. Kidney and urinary tract
2. Metabolic disorders (carbohydrate, fat and protein metabolism)
3. Central nervous system
4. Gastric disorders
5. Liver and biliary tract
6. Intestinal disorders
7. Pregnancy
8. Blood diseases
9. Respiratory diseases
10. Endocrines
11. Cardiac diseases
12. Vitamin deficiencies
13. Bone diseases
14. Infectious diseases
15. Muscular system
16. Melanotic tumors

Urine: Qualitative

Appearance, color, odor	1, 2, 5, 7, 11, 16
Reaction	1, 2
Albumin	1, 2, 7, 8, 11
Bence-Jones protein	8, 13
Reducing substances (glucose)	2, 3, 7
Identification of particular sugar present	2, 7
Acetone	2
Aceto-acetic acid	2
Oxybutyric acid	2
Bile (pigments and bile salts)	5, 8
Hemoglobin (blood)	1, 8, 11
Indican	6
Melanin pigment	16
Leucine and tyrosin	5
Homogentisic acid	2

Urine: Quantitative

Volume of 24 hour sample	1, 2, 4
Specific gravity and total solids	1, 2
Total acidity	1, 2
Total nitrogen	2
Urea nitrogen	2
Ammonia nitrogen	2
Urea nitrogen-ammonia nitrogen ratio	2, 5, 7
Creatinine	1, 15
Creatine	15
Reducing substances (glucose)	2
Chlorides	1
Alkali tolerance	1, 2
Modified Mosenthal	1, 8
Dilution and concentration	1
Phenolsulphonphthalein	1, 4
Galactose tolerance	5
Urobilinogen	5, 6, 8, 11
Ascorbic acid	5

Gastric Contents

Free hydrochloric acid	4, 8
Total acidity	4, 8
Lactic acid	4
Combined acid	4
Hemoglobin (blood)	4
Peptic activity	4
Histamine	4

Cerebrospinal Fluid

Appearance	3
Total protein and globulin	3
Hemoglobin (blood)	3
Spontaneous coagulation	3
Lange's colloidal gold	3
Dextrose	3
Chloride	3, 11
Urea	3
Mercury combining power	3
Alkaline reserve	3
Creatine	3
Bromide	3

Stool

Abnormal color, odor and consistency	4, 5, 6
Occult blood	4, 6, 8
Urobilinogen	5, 6, 8
Bilirubin	5, 6

Urinary Calculi

Analysis for calcium, magnesium, ammonium, carbonate, phosphate, oxalate, urate, xanthine, cystine, urostealith, fibrin.

Biliary Calculi

Analysis for cholesterol, bilirubin, biliverdin, bile salts, calcium, magnesium, phosphate, iron and copper.

In conclusion, a word from the standpoint of the director of the chemical laboratory may not be out of place. Many of the laboratories of the larger hospitals are flooded with requests for analyses. I have found that of all the requests for analyses that come to the laboratory only about 40 per cent are worthy of attention. The reason is mainly because some clinicians often make unconsidered requests for complete analyses. A little more thought on the question of what determinations are indicated would remedy this situation. On the other hand, some clinicians err by not requesting certain chemical analyses that can be of aid in the diagnosis.

Christmas at Peralta

GEORGE U. WOOD
Administrator
Peralta Hospital, Oakland, Calif.

DURING the busy year the exigencies of their work give little time for personal relationship between the doctors of the staff and hospital employes. Each Christmas, however, the barriers are let down at Peralta Hospital and the doctors put forth every effort to show the employes a good time.

Last year during the holiday season a group of talented artists, selected from the Peralta medical staff, presented an old time medicine show. The stage was set in a corner of the large dining room. As many of the 247 employes of the hospital as were off duty attended the performance. Among them were nurses, pharmacists, business office employes, telephone and elevator operators, engineers, maids and porters. "Marvelous Mistletoe Elixir, good for young and old, man and beast, a polish and paint remover, cure for corns, warts and bunions, measles, chicken pox, and falling hair and dandruff" was offered for sale to the hospital audience. The barker was portrayed by Dr. Dudley Bell, a local doctor, to whom also goes the credit for the scenario of the show.

Every medicine show has a magician and the Mistletoe Medicine Company was not to be outdone. Dr. Francis S. Bascom, who appeared as "Bimbo the Terrific," held the audience spellbound with his acts of magic, sleight of hand and, of course, the inevitable rabbit appearing from the silk hat.

Dr. Frederick M. Loomis, retired obstetrician, gynecologist and author, and a favorite among the employes, gave the Christmas address and recounted an interesting Christmas spent by him on a boat in the middle of the Pacific Ocean.

Then followed a tap dancing act by Dr. Travis Winsor, an intern, accompanied by Dr. Norman Leet at the piano. Doctor Winsor's expert imitation of Bill Robinson won the hearty approval of the audience.

Two skits based on life in a hospital were presented by a selected cast.

Four surgeons of past outstanding athletic ability danced a ballet with gusto, if not grace, followed by a violin and piano number, which closed the musical portion of the program.

Dr. Dudley Bell, still playing the rôle of the barker, then appeared on the stage to present Doc Wood (George U. Wood, administrator of the hospital), who was responsible for the formula of "mistletoe elixir." Before attempting to sell his product, Doc Wood offered valuable free premiums, which proved to be 60 door prizes won by holders of lucky numbers in the audience.

Just as the program was about to close, a telegram was brought in to Doc Wood, announcing that the board of trustees of the hospital, in appreciation of the loyal and faithful service of the employes, was awarding gold edged premiums. These premiums in the form of bonus checks were passed out to the employes as they filed from the dining room. The program was followed by refreshments attractively served buffet style in the hospital library.

When Winter Comes

MORRIS HINENBURG, M.D.

Executive Director
Jewish Hospital of Brooklyn, Brooklyn, N. Y.

THIS, the third in a series of articles dealing with the factors of seasonal significance in the working calendar of the hospital administrator, relates to the winter season.

A downward trend in hospital occupancy is usually apparent during December; this may be explained, in part, by the preholiday spending program and the consequent deferment of hospitalization and, in part, by the natural desire of persons to be with their families and friends during the holiday season. In January there is a sharp rise in the number of hospital admissions with an even more striking rise during February.

The character of the patient population during the winter season differs from that for the other seasons except during the early spring months. In winter the patients are "a sick house" and require in full measure the preparations made previously for their care. The change is due to the preponderantly larger number of patients admitted for the care of purely medical conditions.

Increased Activity of Staff

The program of the medical staff, organized and started in the fall, has progressed well along its way by winter. During the cold months the services of the medical staff are urgently and intensively required. The pneumonia cases, present in larger numbers than during other seasons, bring into active service the equipment and the services mobilized for this purpose during the fall months. With the use of specific serums and the sulfonamide preparations, the present day treatment of pneumonia has brought about a sharp reduction in the mortality figures for this disease.

A well-coordinated program utilizing all of the resources of the radiologic and laboratory services, the pharmacy and other allied personnel and equipment is essential for the proper administration of these modern therapeutic agents.

In addition to the respiratory diseases and their sequelae commonly expected and provided for during the winter months, communicable diseases begin to make their presence felt. Great care must be exercised by the hospital to control admissions by proper preadmission examinations for the proper segregation of patients suffering from communicable diseases for which the health laws require adequate isolation accommodations. Though all precautions may be rigidly observed, there will be times when general wards may be quarantined through the admission of such patients, thus reducing the hospital's capacity to meet the heavy seasonal demands for hospitalization.

Ambulance Service Utilized

A review of the ambulance statistics for hospitals generally will reveal that the ambulance service is more active during the winter months than during the summer and fall periods. The reasons that appear to hold for this situation in New York City may be related to the drop in the enrollment in the out-patient department. Instead of receiving outpatient department services for conditions commonly treated in the dispensary during the summer months, citizens exercise their privilege of securing ambulance surgeons to treat their ailments at home.

In preparation for the winter operation of the ambulance service, a number of routine procedures must be followed. The personnel assigned to the service should be provided with warm clothing; the patients under transportation must be assured of every provision for their warmth and comfort. The ambulances should be in perfect condition mechanically with heaters and defrosters working efficiently and with adequate safety chains constantly available for application when surface driving conditions require their use. Careful driving on the part of the chauffeurs, a practice that is always desirable, must be constantly stressed during the winter season.

The social service personnel is called upon to serve a larger clientele during the cold months. These patients constitute a group faced by the trying problems arising out of social and economic factors that are sharply emphasized for them by the winter season.

Among the problems that are the lot of the administrator during the winter are those associated with the nursing requirements of "a sick house" and with the incidence of illness among the nursing personnel which may create difficulties in maintaining an optimum personnel strength to meet the nursing services required for the patients. In addition to the regular duties performed by the nursing staff, the educational programs (in hospitals with schools of nursing) impose specific teaching responsibilities upon certain of its members.

Preparation for Spring Class

In hospitals that admit two classes of student nurses each year, the preparations for the spring class are well advanced during the winter months. The shortage of qualified graduate nurses in many sections of the country has led many schools of nursing to increase their enrollments to offset, as rapidly as conditions permit, the loss of nurses to national defense. With the increased number of positions made available by the shorter working day for nurses and with the greater number of student nurses for whom living accommodations must be provided, the hospital is taxed to meet the physical problem of establishing dressing rooms, lockers and other appointments. These requirements are emphasized during the winter more than at any other time during the year.

The onset of cold weather, initiating the continuous sustained heating season, makes imperative the use of humidity controls in the nurseries of the maternity service, maintaining the optimum amount of moisture to ensure the best combination of tem-

perature and humidity for the newborn infants.

The employes' health service, when available in hospitals, receives the acid test of its efficiency during this season. The high incidence of respiratory diseases among employes taxes not only the health service but the personnel strength of all departments. An educational campaign conducted by department heads in cooperation with members of the medical staff on the precautions to be observed in preventing illness as well as the prompt reference of ill employes for medical care serves as a valuable method of keeping employes at their work with a minimal loss of time.

The storms of winter call for prompt action by a crew of hospital employes to clear the sidewalks, driveways and all entrances and exits. Sand boxes, filled and ready for use, and snow removal equipment in good mechanical condition are essential for winter service.

One of the most annoying problems that the administrator is called upon to meet each winter season has to do with the carelessness and the neglect of staff physicians in utilizing the existing safeguards for the protection of their heavy coats and the contents of coat pockets against petty thievery.

Many hospitals still follow the custom of holding an open annual meeting shortly after the turn of the year to present to the public an accounting of the progress made during the past year and to outline the social program for the ensuing year. The election of officers and members of the governing board is an important part of the business of this meeting. Friends of the hospital, public officials and those with broad communal interests serve to promote, in an approved manner, the public relations program of the hospital. Meetings of this character, planned carefully in advance, serve their purpose best when the material presented by the speakers conveys the broad social implications of the work done by the hospital.

It is during the winter season that the governing board as a body is more active in the affairs of the hospital. In communities in which fund-raising campaigns are conducted during the spring months the plans of preparation and the organization of committees to cover the representative groups in the community are worked out in detail during the winter months.

This work preparatory to a drive calls for direct participation by many who are active in hospital service, creating through these merged interests a strong bond of understanding between the public and the welfare services as to the true position of the hospital in the scheme of communal organization. It is essential that this form of participation be active and not passive on the plea of pressing commitments to other important services.

With the turn of the calendar year during the winter season the administration must set in motion the machinery authorized and provided for in the approved budget for the year ahead. However, the budget must retain a controlled flexibility of character to meet unexpected exigencies if the institution is to maintain an approved standard of service. Under the conditions that prevail today what is essential in hospital work will be maintained with difficulty and by means of constant vigilance and perseverance.

Give Your Board a Square Deal

ALMA LEWIS

Superintendent, Fayette Memorial Hospital, Connersville, Ind.

MADAM SUPERINTENDENT:
Do you ever hide behind the board when you have a rigid rule that you feel should be enforced for the good of your hospital and yet a rule that you think will chafe your employes?

Doesn't it just seem definitely to settle things when you say "the board" would not approve of too much use of the elevator? It is so much easier than for you to explain about the wear and tear on the elevator, the cost of electricity and, perhaps, the noise involved. Yet it seems hardly fair to make your board serve as a shock absorber when the way is full of ruts and washouts.

You are both the eyes and ears of the board. It is through you that its members learn of the developments in the hospital field as well as its needs. Consequently, it is up to you to keep their vision undimmed by bringing them reports of new equipment available and of how neighboring hospitals handle problems similar to theirs and by placing the problems of your own hospital before them in a clear and unbiased manner. This will aid them materially in their undertakings and achievements. The future of your hospital is based on such an effort on your part.

The board should realize some personal gain from its service to your hospital; not material gain, of course, but the pleasure of new associates, a better understanding of the community and its needs and, above all, the feeling of a great humanitarian task well done.

No two groups are so closely connected in working for the same purpose and yet are so far apart as the hospital board and the hospital's employes. Many nurses feel that the board holds a whip over their heads. In most instances, this is not true. Would not personal acquaintance with the staff make the board member better able to counteract erroneous reports that may come to him concerning the hospital and give him a basis for fair decisions on complaints made against the service? Wouldn't the same personal contact make the nurse realize that the board member is an open-minded individual capable of making fair decisions rather than just a voice in the dark that indirectly controls or affects her?

So, Mesdames Superintendents, now that the holiday season is approaching, why don't you give your board members a Christmas dinner? Serve them turkey and all the good things that go with it and finish with a blazing plum pudding. Then the next time they hear the townspeople complain that they never had anything to eat in the hospital except soup and milk they will understand that they were on a Sippy diet and that it was not the fault of the hospital's dietary department.

What Are *Your* Opportunities for Advancement?

Some small hospital administrators are mired in the bog of their multitudinous duties, but the majority of them, like the 14 men and women represented here, find renewed vigor in refreshing hobbies, diversion in club affiliations and zest for the upward climb in sighting a goal for attainment

THE opportunities for personal advancement available to administrators of small hospitals vary widely. However, they do not vary any more than the extent to which administrators make use of the opportunities that are available to them.

In a questionnaire answered by 14 administrators of hospitals with capacities ranging from 35 to 110 beds, several striking facts were revealed. The first question asked whether the administrator has a professional library on hospital administration. Thirteen replied "yes" to this question; only one said "no." In seven cases the library belongs to the hospital, in two cases to the administrator personally and in four instances it is partly the administrator's and partly the hospital's.

In one instance the professional library consists exclusively of copies of the hospital magazines and Hospital Yearbooks. In another case the administrator says it is "very small." Two libraries consist of only three volumes, one of six volumes and one of ten volumes. The five others contain from 15 to 25 volumes each. A list of approximately 20 books costing altogether less than $50 would probably include all of the books on hospital administration *per se* that would be used in a small hospital that does not have a school of nursing. Such a list may be found in the *1941 Hospital Yearbook* on page 919.

Administrators or hospitals that cannot afford to spend $50 to have a small working library on hospital administration need not thereby be cut off from the material in such a library. The Bacon Library of the American Hospital Association will now lend books to anyone interested in hospital administration. All of the books that constitute the nucleus of an administrator's library may be borrowed from the Bacon Library merely for the cost of the return postage. None of the 14 administrators replying to the questionnaire make a habit of obtaining literature on hospital administration regularly from this or from any other library.

It is, of course, a responsibility of the hospital magazines to help administrators keep abreast of developments in hospital administration. Only four of those replying, however, have a regular time for reading hospital magazines. One of them says he reads "as much as possible" and two are unable to estimate how many hours per month they devote to the magazines. Three reported spending less than five hours per month; two spend from five to nine hours, and five spend ten hours per month or more. One of the last group reported twenty hours monthly spent on the hospital magazines. Twelve of the fourteen administrators said that they read both the editorial text and the advertising. One other said that she reads part of the advertising.

The development of hospital institutes has evidently been a great boon to these administrators. Eleven of them have already attended institutes and the other three said "not yet" but evidently intend to do so as soon as possible. Thirteen of them attend hospital conventions reasonably regularly and the other does so occasionally. Four administrators usually go to one convention a year but occasionally go to an extra one; five ordinarily attend two conventions (usually a state and a national meeting); two administrators regularly attend three conventions (state, regional and national); two others go to four or five conventions, and one administrator attends one state, one national and monthly meetings of the Greater New York Hospital Association.

It is interesting to note that hospitals pay the cost of attending conventions in 10 cases, the individual in three and the cost is shared between the hospital and the administrator in one case.

Administrators were asked how much time they have for reading outside of the hospital field. The answers varied widely. Three were indefinite, three reported "very little," two said "considerable," one reported 30 hours per month, three said 60 hours per month and two said from 60 to 90 hours per month.

Favorite nonprofessional magazines covered a wide range of reading interests. *Reader's Digest* was easily the most popular with 10 readers of the 14 replying. Next come *Life* with eight readers and *Time* with four. The *National Geographic* was mentioned three times. *Red Book, Saturday Evening Post* and *American* were each mentioned twice. Magazines given one mention each were: *Yale Review, Better Homes and Gardens, American Home, Vogue, House and Garden, Golfing, American Historical Journal, Rotarian, Sports Afield, Esquire* and *Collier's.*

In the book field, the interests were almost as widely dispersed. Four people mentioned that they belonged to one or two book clubs and read the current selections regularly. Two mentioned only current fiction. There was one mention each for books in the fields of psychology, economics,

biography, historic novels, "best sellers—fiction and nonfiction." The only two books mentioned by name were "I'd Live It Over" and "Oliver Wiswell."

The outside organizations to which these administrators belong are, of course, limited somewhat by the communities in which they live. Most of them are in small towns; none are in metropolitan areas. Women's clubs lead the list. Three administrators mention only "women's clubs" without identification. Two speak of the Business and Professional Women's Club and one mentions a business women's organization. Two of the men mention Rotary and one man and one woman mention the American Legion. Church organizations are mentioned by two administrators, although undoubtedly more than two are members of their local churches. Organizations that were each mentioned one time are: music study club, welfare organization, Masonic lodge, chamber of commerce, discussion group, American Red Cross, literary club, fraternity, country club and boat club.

Of those administrators who indicated how much time they could give to these outside organizations, seven said "very little." One reported six hours per month and two said from 15 to 20 hours per month.

The time devoted to recreation and hobbies likewise varies widely. Three reported that only a "little" time could be spent this way and one said that it varied. Two administrators reported about 12 hours per month; three estimated that they spend from 20 to 24 hours monthly. One each reported 30, 45, 60 and 120 hours.

This time was devoted to many different activities. Golfing was mentioned by four administrators, gardening by three and bridge by three. Outdoor life was popular with a great many who spoke of horseback riding, picnics, tennis, swimming, hiking, winter sports, fishing (mentioned by two women but no men). Knitting for the Red Cross, motoring and movies were also mentioned. One administrator spoke of music while another said "playing cards, if absolutely necessary."

An administrator who is devoted to gardening reports that she has cleared 3½ acres for truck farming and a small flower garden. She has grown all the hospital's fresh vegetables and will have winter potatoes, onions and cabbage.

"The superintendent of a 60 bed general hospital," writes another woman, "with no business manager and only a part-time assistant has her hands pretty full with the job itself. There is little time left for anything else. After 5½ years here, I find that I've just begun."

The final question on the inquiry asked whether the administrator has a personal, professional goal "which you expect to reach 5, 10 or 25 years hence."

Ten of the administrators stated that they have such a goal. For five of them it is simply to become a better administrator. Four are more definite. One wants to be an M.D. One desires to become superintendent of a children's hospital, one wants to take a course in hospital administration and another, similarly, wants to attain a degree in hospital administration.

The most interesting reply came from the administrator of a 72 bed hospital in Ohio. "Administration," she writes, "is my greatest interest in life, especially the upbuilding of small poorly managed institutions. I aspire to the time when it will be possible to be consultant with superintendents of small hospitals in order to help them bring their hospitals to a standard whereby not only would their community be proud of them but the American College of Surgeons would be proud to give them approval, even though they may have only 30 beds."

While, from this review, it is apparent that there are real obstacles facing administrators of small hospitals who wish to advance, it is also apparent that many of them are determined to overcome them to the best of their ability.

It is obvious that one of the greatest aids would be for small hospitals to give their administrators sufficient assistance so that they could budget their time effectively and could read the professional magazines, the important books on hospital administration, the significant general magazines and books, and could make appropriate social and professional contacts in the community and still could have reasonable opportunity to indulge in hobbies and recreation.

Unusual Occurrences Reported

ROUTINE PROCEDURES are well covered by instructions issued from time to time under various headings. However, in spite of all efforts to meet every possible situation, almost anything can happen in a hospital.

An unusual occurrence is defined in this hospital as "any procedure, not routine, that may occur at any time or at any place in the institution in which a patient is involved." Immediately following an unusual occurrence in Alameda County Hospital, a "Report of Unusual Occurrence" is made, identifying the patient, giving his diagnosis and describing the occurrence. When this is written and signed it is handed to the intern, who writes his own observation as to any complications or injury resulting from the occurrence. The statement of the supervisor is added, the completed report is sent to the office of the superintendent of nurses for her comment and then is delivered promptly to the superintendent of the hospital.

This report has certain definite values. The personnel is made to feel that there is no lack of care or carelessness. If a patient dies in the operating room, for example, the report is made and within a few minutes it finds its way to the office of the administrator. He is aware of the event and is able to meet any situation that may arise with the family or the community. Every person in the organization knows, too, that such events have far-reaching effects and all strive to make such occurrences as infrequent as possible.

—MARGUERITE L. MACLEAN, R.N., *Alameda County Hospital, Oakland, Calif.*

For Patients Only

LLOYD C. DOUGLAS
Novelist and Clergyman

I HAVE often wondered if it might not be an interesting experiment in a hospital to hand each patient—on arrival or as soon as he is able to read anything—a little manual of advice.

As the matter stands, it's nobody's business to offer counsel on this subject. A few stark injunctions are tacked to the wall. Don't clog the plumbing. Don't throw banana skins out of the window. And so forth.

Imaginary Booklet

A little booklet might run something like this:

"We are honestly sorry for people who, through no fault of their own, are obliged to undergo discomfort, pain and boredom in this hospital. But it is not our fault, either, that you encountered the illness or accident that brought you here.

"This is not a hotel. Hotels must pay for their own way or close up. Hospitals do not pay their way, but they do not close up; for, at the end of the year, the deficit is absorbed by a company of kindhearted people who believe that we are trying to do our best. We hope you will share in this belief; it is important to your comfort—and perhaps also to the promptness of your recovery—if you consider this place as a friendly refuge, not a mere money-making repair shop.

"Our nurses are well trained. Part of this training is in the control of their personal feelings. If they do not seem much upset over your gas pains, that does not mean they are indifferent; it means only that they are disciplined. They have many distasteful tasks to perform and they do them without showing how they feel on the subject, but that does not mean they are insensitive. They are just as human as anyone else, have their own little frets and forebodings, their days of disappointment and depression. Sometimes a patient's cheerfulness will help a nurse to a fresh grip on herself.

"Your doctor wants you to get well as rapidly as possible. In this matter, you and he share the same wish. He will appreciate your full cooperation. Some morning when you are feeling unusually well you may offer him a little witticism and be dismayed to note that he fails to respond to it. But that isn't because he is indifferent. More likely it is because he has just put in an hour and a half of tense and trying service in the operating room and he doesn't feel jocular. If he can sense your sympathetic understanding of his mood, your attitude will be of much benefit to him.

"In short, if you want to get the largest degree of satisfaction out of your experience in this hospital, join hands with us, almost as if you were a member of the organization.

"If you believe in the hospital and in the skill and sincerity of the doctors and nurses, you will not be troubled by the little vexations and irritations which menace the peace of many patients.

"Perhaps we who are devoting our energies to the care of the sick and injured should be contented if we were able to dismiss you fully restored and just as sound as you were before.

"But we have an ambition still higher than that. It would gratify us immensely if when you leave us to resume your activities you might go out not only repaired physically but revigorated both in mind and in heart.

"In the normal ways of an uneventful life, people do not often have a chance to find out how much pain they can endure or how long they can wait. Here they can take their own measure and discover their strengths. Many a man, in peace time, has wondered how stalwart he might be on a battlefield, facing danger, risking agonies. Circumstances may provide him a chance to learn in the hospital whether he has what it takes to be a good soldier. We do not conduct these examinations. The patient examines himself and marks his own grade. Ever afterward he will be pleased and proud if he passes with credit. No matter what may happen to him in the future he will always know exactly how much disappointment, anxiety, inconvenience and pain he can stand. It's worth something to a man to find that out.

Test Your Own Courage

"So, if you have been informed that the doctor is taking out your stitches tomorrow, you can do yourself a good turn that will last you all your life if you face up to this in the morning without flinching. You have always wondered when you saw others in trouble whether you could take it. Now you know. It's a very gratifying thing; almost everybody finds out that he is braver than he thought he was. It's worth going through a lot of perplexity and pain just to be assured on that matter.

"Sometimes people who hadn't succeeded in making anything very important of themselves, either inside or outside of themselves, have discovered during the enforced leisure of a convalescence certain neglected gifts which they have thereafter exercised to their immeasurable satisfaction.

"In many instances, this self-discovery has resulted in such a marked expansion of interest and success in after-life that the beneficiary has wondered whether destiny had not shunted him off his course in order to permit him to take stock of his resources.

"We suggest, therefore, that you give a little thought to this subject while you are with us. Was it an accident? Was it a misfortune? Was it a mishap that brought you here? Think it over. We think about it a great deal."

This quotation is from "Doctor Hudson's Secret Journal," the novel by Lloyd C. Douglas, and is reprinted by special permission of Houghton Mifflin Company, 2 Park Street, Boston, the publishers of "Doctor Hudson's Secret Journal," "Magnificent Obsession" and other books by Lloyd C. Douglas.

A Job for Every Trustee

R. S. HUNTINGTON

Chairman, Board of Governors, Greenville Hospital, Greenville, S. C.

THERE is no lack of individual work for every able and willing hospital trustee. Much of it he can do better than the employed staff by reason of his position, intermediate between the hospital and the community, representing one to the other. In general, such work savors of public relations for the trustee usually is a layman and frequently is an influential member of the community.

Hospital service is a highly specialized business and it is little understood by people at large. They often do not see beyond its obvious function of healing wounds and broken bones and allaying fevers. In their own businesses, they are tolerant of records, routines and reasonable delays. They understand laborious processes necessary to the excellence of the service which they seek to render. Entering the hospital, however, they are often intolerant of any routine that seems to them apart from the burning issue of immediate care and cure.

Trustees Interpret Services

Each trustee, therefore, sensitive to both angles, can intelligently and entertainingly describe the workings of the hospital to whatever persons, groups and organizations he may have influence with, demystifying and humanizing its operation. There is an eager demand in nearly all clubs for new and interesting programs.

The trustee may well draw his listeners into closer and less formal contact by answering their pet questions about the hospital (how enlightening they often are) and by leading brief general discussions. Such spread of knowledge in the community will be reflected in smoother transaction of business in the hospital office. When radio time is available, able trustees may reach the community with informative, reassuring messages. Their own public standing gives emphasis.

As every trustee stands with his finger on the collective pulse of a good part of the community, he is in position to know its reaction to the institution, whether cooperative, antagonistic or merely ignorant, and to bring his diagnosis to the board for its guidance. Among the cooperative or potentially cooperative citizens he may have influence to direct thinking along effective lines, even to the point of bequests or gifts.

Variety in Membership

An able board of trustees will include members of broadly varying abilities and influence. It should be chosen with this end in view. A newspaper man or other member with a talent for publicity should handle this important side of the hospital's interest.

Greenville General Hospital, Greenville, S. C., is thoroughly a community institution, owned by the city, but receiving supplementary support from the county and serving a county-wide community without discrimination. About 48 per cent of its service is charity. The mayor and one councilman, by requirement, are members of its board of trustees. These two constitute a committee to which all questions of civic relations are referred. In the nature of the committee's organization such questions as aid in care of grounds by the park commission, various public services, city accident cases, city employe cases and prison cases are not infrequently referred to its members. They discuss these questions as may be necessary with civic authorities and committees of council, settling them or reporting them to the board.

Another member, a textile mill executive, is the board's authority in hospital dealings with the large manufacturing portion of the community, making investigations and studies when needed and reporting findings to the board. It is further fortunate that the same man has made a special study of insurance matters and he, with another member, comprises a committee to study and advise the board regarding insurance needs. The delicacy of this function of public relationship may well be appreciated in the case of a city owned institution, with nearly a million dollars of insurance to divide satisfactorily among many taxpaying citizens in the insurance business.

To another member (or pair of members) especially interested in social phases may well be assigned continuous contact with the operation of clinics and emergency rooms. These departments, dealing often with ignorant and excited persons, may give rise to more misunderstandings and complaints than any other department in the hospital. These members become familiar with the organization and special problems involved in this work, make invaluable suggestions and recommendations and investigate complaints in the department with impartiality.

Board Gives Technical Counsel

The Greenville Hospital, having grown in ten years from a 100 bed to a 300 bed institution with almost completely new equipment, has found itself involved in almost continuous problems of building. A hospital administrator is expected, as a matter of course, to be "all-in-all" but, perhaps, a knowledge of concrete mixtures, foundations, steel work, boilers and electrical wiring is asking a little too much, even with the services of a capable engineer; here the contractor and public utilities members of the board have taken over and constituted an engineering consultant committee which has

made many suggestions and allowed nothing amiss to "get by" from the point of view of the board.

Different institutions in different localities will present to their boards of trustees many different types of problems, but there should be members on any well-constituted board who are particularly qualified and interested in dealing with each one.

Put the trustees to work on these problems singly or in pairs. It will promote them from the too common class of "honorary" to the community bestowed degree of "honorable." It will immensely increase their own real interest in the institution; such interest, having been developed, cannot help exuding in the form of enthusiasm on many occasions to the untold benefit of the hospital and the community. Other things being reasonably equal, the best hospital will be the one that has the most interested and active board of trustees; the resulting benefits are without a cent of cost to the institution.

At least a monthly meeting is a matter of necessity. There is always plenty to do and to discuss in an active institution and board. At the Greenville General Hospital we have found noon the most convenient time to meet, with luncheon served by the hospital to the trustees at one o'clock. This routine is almost painless in that it interferes to the minimum extent with the business and social engagements of the board members.

The first hour, for formal meeting, usually disposes of routine business but invariably starts many incipient discussions (good evidence of the trustees' interest but often revealing ignorance of operating details), which are the bane of the chairman who is a good parliamentarian. The second hour, at the luncheon table, disposes pleasantly of the discussions, everyone expressing himself freely, sans gavel; general knowledge of hospital operation by the trustees is increased and little important time is lost. Man must eat anyway and it is the hospital's concern to express its appreciation of his service and send him on his way happy and glad to come next time.

A most valuable general relations contact of the board is a quarterly meeting and supper at the hospital held jointly with the medical committee of the hospital staff. This takes the place of the current meetings of the board and committee, each of which holds a brief separate session for transaction of routine matters before meeting for supper. Since the board of trustees must take cognizance of and finally pass on matters of medical policy, the technical side of which it has little basis for appreciating, this regular joint meeting four times a year gives the trustees the opportunity for learning the professional viewpoint and discussing the pros and cons with the medical authorities.

Such a gathering brings the trustees into much closer contact with the medical staff, preventing misunderstandings, and not infrequently it forestalls the growth of minor situations into major problems of relationship. Truly, this is an important factor in public relations.

Next, and along similar lines of mutual understanding for institutions owned by or receiving support from public bodies, is an annual dinner meeting of the trustees with the public representatives concerned. In our case there are two such meetings, one with the city officers and council as guests and the other with representatives of the county government. Both bodies inspect the institution with the trustees and then, following dinner, hear reports of those phases of operation in which they are interested. These are followed by free general discussion and the answering of questions that have arisen.

In this way the public authorities are kept in intelligent touch with the facts of charity service being rendered by the hospital in the community and are posted as to further opportunities and needs.

Finally, an annual dinner by the trustees to the entire medical staff is well worth while. Here, again, is an opportunity for the lay members to understand and appreciate more fully the medical functioning of the institution and, quite as important, for the doctors to learn something of the hospital's economic and business problems. Also, it is a worthy recognition of the unselfish and devoted service rendered through the hospital by the doctors of the community to the community.

WOMEN'S SERVICE GROUPS

They Show Personal Interest

• Personal contact with the little patients in the Children's Country Home, Westfield, N. J., stimulates the enthusiasm of the 60 women who comprise the senior auxiliary. For years they have sent ice cream and cake to the children on special occasions, but during the past two seasons each child has received also a birthday cake delivered personally by some member. Some of the women assist the occupational therapist and read to the children; the chairman of the grounds committee helps those who are able to be outdoors to plant little gardens. A motor corps is available to take the patients to other hospitals for treatment when necessary.

Patients as Volunteers

• The question of whether patients referred by staff doctors should be taken as volunteers as a means of therapy has been brought up for discussion in recent conferences. The general feeling is against such practice, except under special conditions and in certain types of service. Hospital patients should not be jeopardized, according to some; also, the department would be swamped with that kind of volunteer. On the other hand, provided the situation is gone over carefully with the doctor in charge, both the hospital and the volunteer may be benefited.

New Group at Norwalk

• At Norwalk General Hospital, Norwalk, Conn., services of hospital volunteers fall into three classifications: one group acts as receptionists, another cares for flowers and distributes magazines on days when the bookcart is not on duty and the third makes surgical dressings.

Students Benefit

• Last year the women's auxiliary of Grace Hospital, New Haven, Conn., devoted a major share of its efforts to the training school. The reference library was augmented by periodicals and books, arrangements were made for the students to swim and play basketball at the Y.W.C.A. and the hospital tennis courts were put in condition. A recreation fund makes it possible for the girls to have simple parties they otherwise could not enjoy.

Fire Appliances Ready for Duty

LEONARD F. MAAR
Safety Research Institute, New York City

FIRE extinguishers, the first line of defense against fire, are designed to operate with the greatest of simplicity. No particular skill is required to use them effectively, although familiarity with their function is extremely desirable. By their nature, they must be ready to operate in the instant that a fire emergency occurs.

There is, in fact, no reason why an extinguisher ever should fail to operate unless it has not been properly serviced. The servicing of extinguishers is as simple as their operation, yet too often this job is neglected or improperly done. For this reason, the engineer should supervise personally the recharging and inspection of all types of extinguishers. First-aid fire protection is too vital to the welfare of the hospital to be left to the vagaries of the indifferent workman.

It must be kept in mind that the 2½ gallon extinguishers are pressure containers. Extinguishers approved by the Underwriters' Laboratories or the Factory Mutual Laboratories are constructed with a large safety factor, so far as pressure is concerned. This is why fire insurance underwriters insist that extinguishers bear the label of approval of either of these laboratories.

Charged with approved materials, the pressure developed within the extinguisher will not exceed 100 pounds per square inch on free discharge with the solution at 70° F. Even with the nozzle closed and the solution at 120° F., the pressure will not exceed 300 pounds per square inch. This pressure is far less than the tested strength of each approved extinguisher. Manufacturers are required by the approving laboratories to test each shell hydrostatically so it will not show leakage or permanent distortion under 385 pounds' pressure per square inch for one minute.

However, because the extinguisher is a pressure container, there should be no leakage at the cap when it is discharged. This can be avoided by making certain that the head gasket is sound and that the cap is screwed on so at least four threads are engaged. A small quantity of vaseline can be placed in the threads to facilitate removal. Free discharge will not be possible, of course, if the nozzle is clogged, so at the time the recharging job is done the nozzle should be carefully examined and

The student nurses' course on safety at St. John's Hospital, New York City, includes instruction in the proper use of fire extinguishers. This nurse is using a vaporizing liquid apparatus to extinguish a gasoline fire.

Under the watchful eyes of members of New York City's fire department who conducted the training in the use of fire extinguishers, these nurses are cooperating in an effort to put out a fire started in the courtyard.

cleaned out with a stiff wire if any foreign matter clogs the orifice.

The seams of the extinguisher also should be inspected and if there is any suspicion that the seams are not sound the extinguisher should be sent back to the manufacturer for repair. No attempt should be made to solder the seams.

Extinguishers often are dropped, thus distorting the shell; such distortions also should be repaired only by the manufacturer.

Since the operation of the soda-acid and foam types of extinguishers depends upon chemical action within the container, it is important that the shells be well cleaned before being recharged. Each extinguisher should be rinsed out with warm water and the water drained out through the hose. This will remove the vestiges of the last chemical charge that might cause some slight chemical reaction in the fresh solution and so weaken it. The strainer also should be thoroughly cleaned so all its tiny holes are open to permit proper entrance of the solution to the hose at the time of discharge.

All chemical solutions should be mixed in pails or other containers and not in the extinguisher itself. This will dissolve the solid chemicals.

The soda-acid and foam units should be recharged annually and the date and initial of the man doing the work should be noted on the tag provided for that purpose.

It is important to use only replacement parts and recharging supplies obtained from the manufacturer. This is particularly true of the vaporizing liquid type of extinguishers that are susceptible to corrosion if any liquid containing water is placed in them.

Carbon tetrachloride of the ordinary commercial grade is sometimes substituted for the proper vaporizing liquid and the commercial product usually contains some water. The vaporizing liquid supplied by manufacturers of fire extinguishers has a base of water-free carbon tetrachloride to which are added important components for depressing the freezing point and avoiding corrosion.

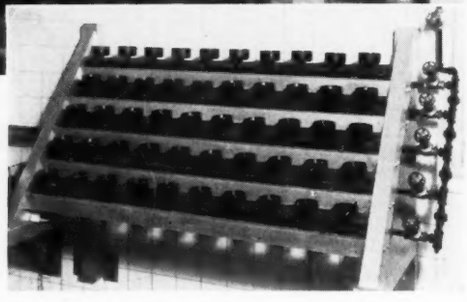
Vaporizing liquid extinguishers can be tested by pumping some of the liquid into a clean dry container and the liquid can be returned to the extinguisher through the filler hole, adding as much liquid as is needed to fill the extinguisher and taking care not to overfill it. Extinguishers of this type should be kept filled at all times and periodic inspection will keep them always in service.

The water pump type of units need only to be inspected periodically to make certain they are filled. The pump action can be tested by pumping the water back into the unit through the filler hole. If antifreeze crystals are to be added to the water they should be dissolved outside the extinguisher.

Extinguishers that use carbon dioxide cylinders for pressure, such as the loaded stream type, need to be inspected annually to make certain they are filled and otherwise in good working order. The cylinder should be weighed and loss of ½ ounce in weight is cause for its being replaced.

Carbon dioxide units should be inspected to make certain the seal at the release valve is intact and they should be weighed annually. Loss of one tenth of the weight stamped on the unit indicates the need for recharging.

All approved extinguishers bear an instruction plate; if there is any question about the proper procedure, the directions on this plate should be followed to the letter.



Glove Drier

D. A. ENDRES

Superintendent
Youngstown Hospital Association (North Side Unit)
Youngstown, Ohio

THE apparatus shown above and at right has been developed and built at Youngstown Hospital to facilitate drying surgical gloves. The drier is mounted on a wooden base attached to the wall; its maximum capacity is 50 gloves.

Two-inch metal pipe caps form the bases over which the glove cuffs are slipped preparatory to drying. Within the cap a pinhole has been drilled; this serves a twofold purpose, acting as a vent for the air and as a drain for the moisture that runs down inside the glove.

When the gloves are ready for drying, between 5 and 10 pounds of air pressure is forced through the pipes, each line of which is equipped with a reducing valve to maintain uniform pressure. The air pressure holds the gloves erect, as is shown in the top photograph, and they require no further attention until they are dry.

Our nursing department is enthusiastic about the apparatus as it saves the time formerly spent in turning gloves and eliminates the irksome task of drying them by hand.

Making the Most of "Leftovers"

MARGARET BYRNS
New York Hospital, New York City

LEFTOVERS! Yes, they are oftentimes the bane of one's existence. It is agreed by all good authorities on food control that leftovers should be kept at a minimum. The ingenious, artful and efficient dietitian can use these leftovers, serve them attractively and make of them money savers rather than money losers.

In considering leftovers and how to use them, we should consider first their origins: (1) inefficient food control; (2) food ordering by guess rather than by knowledge; (3) poor food preparation; (4) unpopular dish on the menu; (5) stereotyped menus; (6) menus planned without regard for seasonal or weather changes.

In spite of watching food control, ordering, preparation and service, the dietitian will still have leftovers with her. Prediction of what each employe, patron or patient is going to consume is somewhat of a gamble. The census from meal to meal seems to vary at times without rhyme or reason. Yet, regardless of this, the dietitian can make her food estimate and with it as a basis she can proceed according to a predetermined efficient plan for food ordering, preparation and control.

Use leftovers immediately. That is the first rule. Use them while the food is still tasty and fresh. Take a complete inventory of iceboxes and storage boxes for leftovers at least once each day. If time allows, it is preferable to take this inventory after each meal. The chef should accompany the dietitian on the icebox tour. He may have many helpful suggestions and it is an excellent way to have him share the responsibility for food control.

No one enjoys seeing the same food served for two meals in succession. If there are a number of service units within one institution it is advisable, if preparation facilities will allow, to plan a variety of menus so that the same food is not served in all service units. With varying menus in the service units, the leftover item from one unit may be substituted in another unit, making it possible to serve the food in its original form.

A pay cafeteria offers an excellent opportunity to use small amounts of leftover foods, which add variety to the menu. An extra pan of this, a leftover cake or pie or some extra fruit may be dressed up and displayed on the cafeteria counter. This may be a favorite and will probably sell like magic.

Oftentimes the leftover food can be disguised or dressed up. It does not always have to find its way into the stock pot or the soup kettle. Following are some suggestions for the use of leftover food items:

Vegetables

1. Small amounts of vegetables, such as peas, corn, carrots, celery, lima beans and green beans, can be combined with a heavy cream sauce, topped with a pastry crust or cheese biscuit, cut with a doughnut cutter (the center hole filled with fresh green peas), and served as vegetable pot pie.

2. The same vegetables can be made into vegetable curry and served on steaming hot rice.

3. Leftover broccoli, cauliflower and cabbage discolor easily. They can be served escalloped or au gratin. Serve escalloped cauliflower topped with buttered, toasted pecan meats for an interesting entree dish.

4. Cabbage can be escalloped with stewed tomatoes and cracker crumbs and topped with crisp bacon curls. This makes another interesting as well as reasonable entree dish.

5. Corn and lima beans left in the icebox at the same time quickly suggest succotash, a favorite dish. It can be served either buttered or with cream. Or make your succotash of julienne green beans and corn; it will be a delightful surprise.

6. Save all baked and boiled potatoes. Hashed browned, pan fried and lyonnaise potatoes can be created from these as can potato salad, for which there is a constant demand and a ready sale.

7. From mashed potatoes and eggs can be made either a delicious, fluffy potato soufflé or duchess potatoes. For the soufflé steam the potatoes, add egg yolks and beaten egg whites, place in baking pan and bake in oven.

8. Sweet potatoes are not a problem as leftovers as there are many ways in which to prepare them. Grilled or glazed sweets can be covered with brown sugar, dotted with butter and candied. Try the new recipe for sweet potatoes Florida. Cover the grilled or boiled sweets with a sauce prepared by mixing brown sugar, butter, orange juice and grated orange rind. Then bake in the oven for thirty minutes. Mashed sweet potatoes can become duchess sweets. If you serve the duchess sweets on grilled pineapple or apple rings, call them sweet potatoes imperial. Steam the leftover mashed sweets, place in a baking pan and cover with marshmallows. Toast the marshmallows well. Perhaps you would like to roll the mashed sweets in cornflakes and fry in deep fat. All these recipes make a hit with patients and employes.

9. Practically every leftover vegetable can be put into a stew, vegetable soup or cream soup. But that is not news.

Meats

1. Hash, stew and croquettes are the most common use for leftover meats. Meat soufflé makes a good change. For the soufflé you can use

fish, veal, ham, pork, lamb, beef or poultry.

2. Hip or French steak makes an excellent Yankee pot roast of beef.

3. Creamed chicken is the proper foundation for baked chicken and noodles.

4. Leftover cooked bacon and ham from breakfast are the fitting finish for luncheon omelette, stuffing for all kinds of meats and sandwich fillings, as well as hot bacon or ham muffins.

5. Cooked ham may be diced and escalloped with potatoes. This is a favorite luncheon dish.

6. Ground cooked lamb may be prepared as a croquette but shaped as a cutlet. This makes an interesting change.

7. Salmon steaks may be served cold on the menu with lemon and parsley. It is needless to mention the suggestion of salmon salad or salmon salad sandwiches. Try stuffing your eggs with finely minced salmon salad and your celery sticks, too.

8. The shrimps from your cocktail can be served as shrimp creole or shrimp Newburg. Serve your creole on rice. Shrimp à la Newburg in patty shells is not a leftover—it is a real party dish.

9. Any fricasseed or creamed meat should be washed at once, if it cannot be reheated in the sauce and used for the next meal. This is the basis for croquettes, hash and soufflé.

Fruits

1. Melon that has been cut and not served can be rejuvenated in a lemon and sugar syrup. Make melon balls with a French cutter. Melon rings or diced melon can be used as a fruit cup or on a salad.

2. Bananas on which the skins have turned dark and are not appetizing for table service make delicious banana bread, muffins or cake.

3. A few leftover cherries, plums or berries make a beautiful garnish for fruit salad.

4. Leftover berries and cherries can be sugared and used for sundae sauces, fruit pies, puddings, cobblers or cakes. Raspberry cake or cherry cake delight the eye as well as the palate.

5. Add sugar, brown sugar or honey, as you prefer, to leftover grapefruit and grill. Serve it as a starter—hot.

From the Bake Shop

1. Cakes that are left over should be re-iced. Usually, the base cake is in good condition, only the icing has spoiled. Put a fresh and different icing on it and a new cake is the result.

2. Leftover cake, white, yellow or sponge, should be made into crumbs which are just the proper thing for those popular fruit scallops or cabinet pudding.

3. Save chocolate cake crumbs, too. They can be made into a delicious chocolate nut pudding. The recipe is given on page 84.

4. Fruit gelatin may be remelted, drained, any discolored fruit removed and fresh fruit added. Use it as a dessert or a jellied fruit salad.

5. Leftover Boston brown bread may be used as a sandwich bread. Mix cream cheese with candied cherries or pineapple and spread it between slices of the bread for a really tempting sandwich.

Dressed for Thanksgiving

HOW will we dress our Thanksgiving trays this year? Possibly we cannot be quite so ambitious in achieving an artistic effect as we might like because of a reduced personnel. Don't let's give up hope, however, until we check to see what outside help is available. The nursing department has its own problems these days, to be sure, but what about the women's auxiliary? Perhaps it will come to the rescue.

There is no better diversion than creating these little seasonal touches that mean so much to every hospital patient. They may be amusing or they may be purely artistic, it matters little, so long as they convey the spirit of the particular holiday.

It is no great trick to fashion a little souvenir in the form of a pine cone turkey—pipe cleaners for the legs and neck and a candy paper cup from a box of chocolates for the tail, applying a touch of red paint about the fluted edge. Try it and see. Once you catch the trick of it substantial numbers can be turned out in a comparatively short time.

If the necessary number of pine cones is not available or if for other reasons the pine turkey does not seem practical, a prune may be used for the body. Half a pipe cleaner serves as the neck, curving it at the end and placing a raisin in the curve for the head. Toothpicks, as well as pipe cleaners, make excellent legs and more raisins can be used for the feet. The dietitian who was telling us about it gives further directions. "I cut tails out of dull orange paper and place them in gashes made in the prunes. I have also used brown paper candy cups for tails. Wax of old red candles dripped on the neck adds a realistic touch."

There may be nothing original about a pilgrim boat, but it is easily made and is always attractive on the tray. Half a walnut shell forms the boat, with a tiny sail of white paper affixed to a toothpick mast. Melted wax in the bottom of the shell will hold the mast properly. If time permits, the word "Mayflower" can be printed across the sail.

A puritan doll sounds far more difficult than it actually is, although there is no use denying that it will take more time than the pine cone turkeys and the pilgrim boat. A candy sucker becomes the body and the face, with a large gum drop used for the base. You don't have to be any kind of artist to fashion a face on a piece of paper and paste it onto the round candy. A black paper hat fixed to the top, a brown crêpe paper cape, arms fashioned also of black paper, and pipe cleaner hands placed in their proper positions complete the figure.

If time does not permit the fabrication of favors, we can at least place on the trays a few baby 'mums tied together with a bit of yellow ribbon or a small yellow candy pumpkin glued to a white card bearing the name of the patient and tied with a green or yellow ribbon. These are simple ways of making those who are hospitalized thankful for such extra attentions.

Times may be difficult, to be sure, but that is all the more reason for using our ingenuity to contrive something from little or nothing. It is the thought that patients appreciate.

HOTPOINT-EDISON HAS A UNIT FOR EVERY COOKING JOB

In Big Kitchens • Diet Kitchens • Cafeterias

NOTHING beats electricity for cool, safe, clean, sanitary cooking. Hotpoint-Edison provides Electric Cooking Equipment for every job.

ELECTRIC COUNTER EQUIPMENT

Charm Waffle Baker plugs in anywhere. Completely automatic. A winner in the cafeteria. Space required 10" x 18¼".

Automatic Electric Griddle Even a probie could grill every order perfectly with this automatic griddle. Two sizes—18"x24" (G-28) and 12" x 24" (G-32).

ELECTRIC RANGES

The New Champ (for the big kitchen)—Low-priced, heavy duty range. Choose baking tops from 35 different combinations. Available with large oven or cabinet base for utensil storage.

Brawny Lad—Low-priced range. Size 30"x32". Flash speed for diet kitchens. All-Purpose Oven.

ELECTRIC BAKING AND ROASTING OVENS

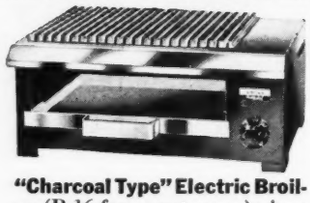
N-222 Bake Oven—Two Baking Decks. 25% faster, 35% more efficient. Capacity, 4 roll pans, (18" x 26"). Each compartment a separate oven provided with flash and solid heat.

N-166 All-Purpose Oven—Cut expenses in the big kitchen or your cafeteria by baking and roasting in this oven. Superior results assured because each section has directional and automatic heat control.

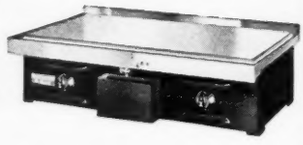
These Ad-A-Deck Ovens can be built up a section at a time.

ELECTRIC KITCHEN AND COUNTER EQUIPMENT

Deep Fat Kitchen Fry Kettles. Hi-Speed Calrod heating units are immersed within the fat. No heat loss. Heat Manager holds temperature accurately. Fat capacity, model K-32 (illustrated), 25 lbs.; K-16, 90 lbs.



"Charcoal Type" Electric Broiler (B-16 for counter use) gives tasty "charcoal broil" taste and appearance without the expense, flare-ups or fumes of charcoal. Kitchen and hotel size broilers to fit into range bank, available.



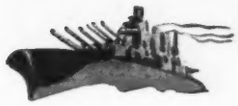
Heavy Service Griddle (G-47 for counter use) with massive cast-iron top and high-wattage Calrod heating unit. Heat can't be killed by ordinary cooking operations. Available with integrally built floor stand.

EDISON GENERAL ELECTRIC APPLIANCE CO., INC., 5662 West Taylor Street, Chicago, Illinois

BOSTON	KANSAS CITY
NEW YORK CITY	DALLAS
ATLANTA	LOS ANGELES
CLEVELAND	SEATTLE
CHICAGO	SALT LAKE CITY

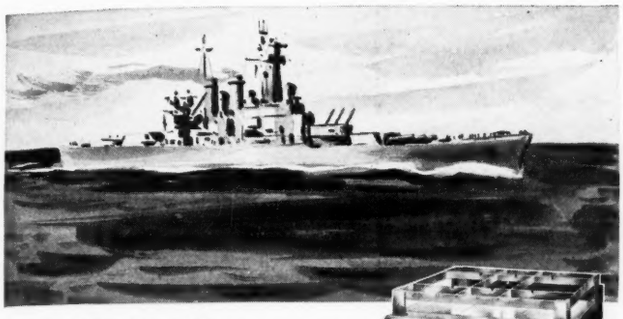
Hotpoint

COMMERCIAL ELECTRIC

On Land  On Sea  In City and In Town

Hotpoint-Edison Electric Cooking Equipment Makes Good Food Better

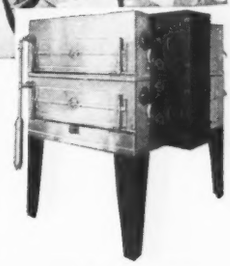
Hotpoint-Edison Electric Cooking Equipment not only gives zestful taste to cooked foods, but it preserves the health-giving qualities and reduces food loss.



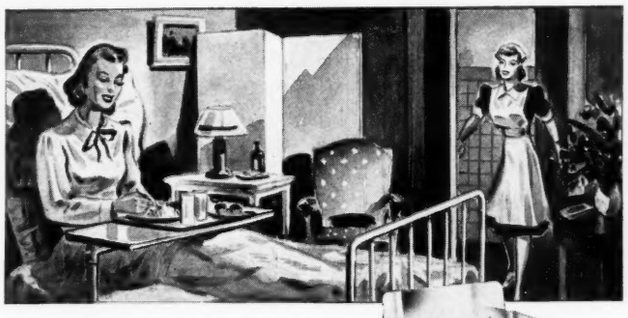
Newest Battleship has a modern galley equipped with safe Hotpoint-Edison Electric galley equipment. When Chief Commissary stewards prepare menus for officers and men you can bet the food looks good, tastes good, and is nourishing. U.S. Navy sailors go to work on full stomachs.

Marine Range R-173

In the Hospitals of nearly 300 army camps, as well as in the camp kitchens, Uncle Sam insures that the nourishing food provided soldiers will be properly and uniformly cooked by using Hotpoint-Edison Automatic Electric Cooking Equipment.



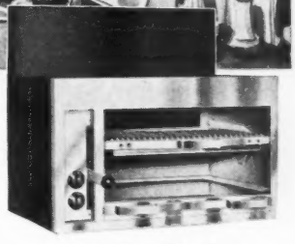
Ad-A-Deck Oven NA-56



Normal Diets may include food fried in Hotpoint-Edison's Electric Fry Kettle because there is a minimum of fat absorption and fat particles are finely distributed for easy digestion. Heat Manager Automatic control eliminates need for skilled cooks.

K-31 Fry Kettle

The Secret Of Making The Cafeteria Pay may be found in Hotpoint-Edison's successful record in chain cafeterias, big-time restaurants and hotel kitchens. Ask for budget-saving facts for hospitals.



B-18 Kitchen Broiler

On Land, On Sea, in City and Town Hotpoint-Edison does a job for users

EDISON
COOKING EQUIPMENT

For sale through leading Kitchen Equipment Houses

•

CANADA—Canadian General Electric Company, Ltd., Toronto

Food or Cash for Employes

A. C. JENSEN
Superintendent, Fairmont Hospital, San Leandro, Calif.

PROBABLY all will agree that, insofar as possible, a hospital should adopt the policy of paying all employes, with the possible exception of medical and nursing students, a fair cash wage. However, if this is not possible, and we must recognize the fact that generally it is not, a modified program should be adopted looking toward this end.

As an illustration of what I mean by a modified plan, in Alameda County, while we required employes to accept maintenance as a part of their salary, we found the following objections on their part:

1. Married employes who were maintaining homes suffered inconvenience as well as loss. Desirable employes with dependents frequently refused employment or left soon after they were employed.
2. Employes lost sight of the value of maintenance, complaining that wages were too low. They felt they could live more cheaply outside. They complained of being charged for meals not eaten at the hospital.
3. There was a tendency for employes to become institutionalized, living too close to one another and to their work.
4. There were all of the usual complaints as to variety, preparation and service of food. All these objections tended to cause dissatisfaction among employes and to affect morale.

On the other hand, the hospital had rooms available for this use. The budget had been established on that basis, and to secure a sufficient increase to allow each employe $45 (the established value of maintenance), additional cash per month was out of the question.

Employes' Quarters Surveyed

The first step was a survey of the quarters occupied by employes. This resulted in the condemnation of one building. Some rooms occupied by two employes were found to be too small and were changed to single occupancy. The policy was adopted that no additional quarters would be constructed for employes, even though it was necessary to increase personnel owing to the growth of the hospital. With these changes it was not possible to house all employes as in the past and some were granted a room allowance of $15 and were permitted to live outside; however, their meals were furnished.

Cash Allowance for Meals

The next step was the granting of a $10 monthly allowance for one meal on the basis that only two meals could be served during the eight hours the employes were on duty. Later, an additional $10 cash was allowed for a second meal, requiring only that the midshift meal be taken; finally, during the past year, arrangements were made for full cash payment of all employes who do not live at the hospital, the only exception being workers in the culinary department. Practical experience dictates that these workers have at least one meal at the hospital.

We now have a total of 300 employes. Only 120 live in the hospital and have maintenance deducted from their salary. Of this number about 70 are students and interns; the remainder consists of single employes who prefer to live in the institution. If an employe who receives maintenance for any reason wishes to change and live outside, his request is granted as soon as a change in personnel makes it possible. Employes who do not live in the hospital may purchase one or more meals per day at $10 per meal for the month, but purchase of single meals is not permitted.

The evolution of this procedure took twenty years, but we believe that the results justify the effort and the additional expenditure.

With a satisfied group of employes it is comparatively easy to maintain a high standard of morale. One of the results of this change of policy has been to attract to the nonskilled jobs a more stable group of employes who have homes in the community.

In reviewing these fairly obvious advantages, we should also consider disadvantages. Hospitals generally are recognizing their responsibility as leaders in all matters pertaining to health. One of the ways in which this is demonstrated is the general acceptance of the policy of physical examinations before employment and periodic physical examination of employes thereafter.

Health Is Factor

Proper eating habits are obviously a factor in maintaining employe health. We have not been operating under our present plan long enough to determine whether employes who do not have maintenance take as good care of themselves and remain as healthy and efficient as those who live at the hospital. In discussing this with our executive dietitian, she commented:

"We have heard employes say that they can save money by eating away from the hospital. Usually, when they do so, they are eating a scanty breakfast and have sandwiches and coffee or fruit for their noon meal. The evening meal is depended upon for the bulk of the food consumed. Some state that one meal a day is really all they eat or care to eat.

"Nutritionists agree that it is practically impossible to obtain proper nutrition on such a regime. Definite and striking nutritional deficiencies may not be seen. The result may be hidden diet deficiencies with largely subacute and chronic symptoms. Such undernourished persons will not give the highest type of service during employment hours."

As an indication of the value of necessary nourishment during working hours, women employed in our laundry at Fairmont are given a short relaxation period in the middle of the afternoon. They may, and frequently do, partake of food which

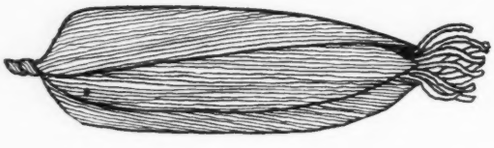
From a paper presented at the convention of Association of Western Hospitals, San Francisco, March 1941.

HOLIDAY TRAY DECORATIONS

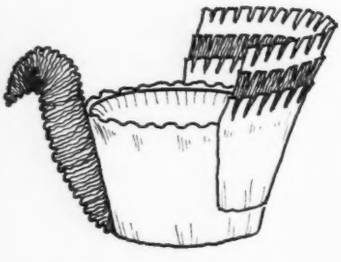
Suggested by New Jersey Dietetic Association

This little Indian boy stands on a paper cup 1 inch in diameter and 3 inches high, filled with candy mints. His face is a common bottle cork (1 by 1½ inches) with features inked in. The hair is strands of black knitting yarn, around which a head band of brown crêpe paper is fastened. On the left side of the band three chicken feathers (3 by 4 inches long), dyed yellow, maroon and green, are tucked. The shoulder cape is made of brown crêpe paper (5 by 8 inches), upper 1½ inches folded over to form the top; a pin holds it securely.

Leaves of two-toned orange crêpe paper (5 inches long) form the background for this soufflé cup favor. The cup is covered with green crêpe paper and the white card on which the greeting and name are printed is affixed at the base of the cup.



This attractive ear of corn is made of three leaves of green (2½ by 8 inches) and six leaves of yellow (3½ by 8 inches) crêpe paper. Corn silk is brown crêpe paper cut into strips. The leaves are wrapped on a piece of circular cardboard.



A soufflé cup (2 inches in diameter) covered with brown crêpe paper forms the body of this turkey favor. The head and neck are made of 2 inches of orange and 2½ inches of brown crêpe paper folded and pasted to form a strip ½ inch by 4½ inches. This strip, then, is placed on a 3½ inch length of wire and crushed to 3 inches. The tail is made of strips of orange, brown, yellow and green crêpe paper, about 3 by 5 inches, pasted to the cup.

An unusual favor and easy to make is this Pilgrim's hat. The brim is black cardboard, 3½ inches in diameter, in the center of which an inverted dixie cup (1½ inches high), painted black, is glued in place. A black ribbon laced through the tinfoil buckle is tied in a bow at the back.

they have brought from home and are served coffee, with cream and sugar if desired, and graham crackers. This has made a decided improvement in the quality and quantity of work accomplished by them in the late afternoon.

If it is necessary for a hospital to require its employes to accept maintenance as a part of their compensation and to require them to live in the institution, everything should be done to make conditions as homelike as possible. Reasonable opportunities for recreation should be provided as well as pleasant dining rooms where well-prepared food with varied menus is served. No hospital is justified in seeking to make a profit by requiring employes to take their meals in the hospital.

RECIPES BY REQUEST

Old-Fashioned Chocolate Nut Pudding

(Twenty-Four Servings)

2 quarts cake crumbs
1 egg yolk
½ tablespoon soda
1-1/7 quarts buttermilk
¼ cup sugar
¼ pound chocolate
1 teaspoon vanilla
½ cup nut meats
½ cup egg whites

Combine the soda and buttermilk. Add to this the egg yolk and sugar and melted chocolate. Add all to the cake crumbs. Add nut meats and vanilla. Fold in well-beaten egg white and pour into baking pan. Bake in 350° oven from thirty to forty-five minutes. Serve with sauce suprême.

Salmon Pie

(Fifty Servings)

1½ cups shortening
1½ cups flour
4 cups milk
4 cups chicken soup
4 teaspoons Worcestershire sauce
8 No. 1 tall cans salmon
12 cups diced cooked potato
24 hard cooked eggs
Biscuit dough
Salt and pepper to taste

Make a sauce of the shortening, flour, milk and chicken soup. Add seasoning. Separate salmon and remove bones and skin. Lay salmon in pans, add diced potatoes and sliced eggs. Pour the sauce over and top with baking powder biscuits. Bake in hot oven until biscuits are done (425° F.).

"KELLOGG'S INDIVIDUALS ARE A 'MUST' AT NEW YORK POLYCLINIC HOSPITAL"

Says

RUTH BIGELOW, B. S.,

DIETITIAN

★ Call the roll of America's leading hospitals and each in turn will tell you that Kellogg's are a menu "must." The choice of 8 varieties makes breakfast *different* . . . a stimulating event . . . each patient receiving a generous portion of his favorite Kellogg cereal in a sanitary Individual package.

Kellogg's Individuals are a boon to budgets, too . . . eliminating cereal waste and work in the kitchen . . . permitting exact cost-control.

Be sure to specify Kellogg's Individuals when you order. Your wholesale grocer always has a fresh supply. Packed 50 Individuals or 100 assorted to the case.

"They give pleasing variety . . . accurate cost-control . . . correct portions."

AS THEY DO AT HOME... LET YOUR PATIENTS TAKE THEIR CHOICE OF

Kellogg's CEREALS

MADE IN BATTLE CREEK

December Dinner Menus for the Small Hospital

Estella O. Yaudes

Dietitian, Clearfield Hospital, Clearfield, Pa.

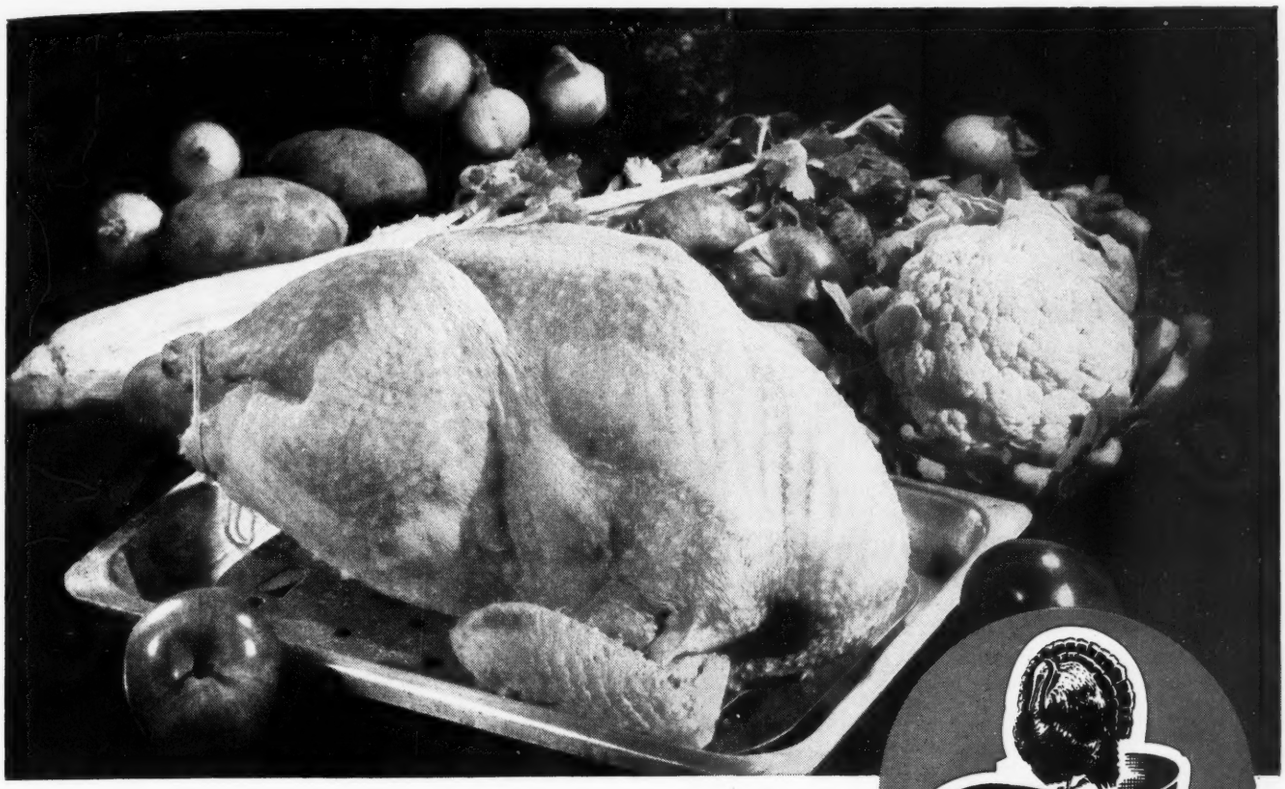
Day	Soup or Appetizer	Meat or Fish	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Tomato Juice, Triscuits	Baked Ham With Sautéed Apple Rings	Sweet Potato Croquettes	Creamed Cauliflower	Beet Relish	Walnut Ice Cream
2.		Roast Leg of Lamb With Gravy	Mashed Potatoes	Buttered Green Lima Beans	Julienne Raw Carrots	Tapioca Apples With Whipped Cream
3.		Roast Beef With Gravy	Steamed Rice	Buttered Small Onions	Coleslaw	Cranberry Whip
4.		Broiled Liver and Bacon	Creamed Potatoes	Buttered Green Peas	Cabbage and Green Pepper Relish	Prune Whip With Whipped Cream
5.		Fried Halibut or Swiss Steak	Baked Stuffed Potatoes	Spinach With Riced Egg	Pineapple Slaw	Apple Butter Tarts
6.		Hamburg Roll	Parsley Potatoes	Buttered Blue Lake Beans	Sweet Pickle-Relish Salad	Tapioca Cream
7.		Lamb Chops	Escalloped Sweet Potatoes	Shoestring Beets, Howard Style	Celery Hearts and Pickles	Fruited Gelatin
8.	Cranberry Juice Cocktail	Roast Leg of Veal, Mock Dressing	Mashed Potatoes	Buttered Golden Bantam Corn	Whipped Cream Coleslaw	Butter Pecan Ice Cream
9.		Beef Stew With Potatoes and Dumplings		Frosted Buttered Lima Beans	Beet-Horseradish Relish	Lemon Meringue Pie
10.		Baked Ham, Raisin Sauce	Potato Croquettes	Buttered Asparagus Tips	Raw Cranberry Salad	Caramel Custard
11.	Noodle Soup	Veal Salad	Potato Chips, French Rolls	Buttered Green Peas	Julienne Raw Carrots	Cherry Pie
12.		Broiled Salmon	Creamed Potatoes	Buttered Corn	Celery, Cucumber Pickles	Lemon Meringue Pie
13.		Roast Beef With Gravy	Buttered Rice	Harvard Beets	Quick Coleslaw	Fresh Fruit Cup
14.		Spanish Steak	Mashed Potatoes	Buttered Asparagus	Celery	Cheese Apple Crisp
15.		Chicken Stew With Hot Biscuits	Mashed Potatoes	Buttered String Beans	Coleslaw	Almond Ice Cream
16.		Pot Roast With Gravy	Boiled Potatoes	Succotash	Dill Pickles	Prune Whip, Custard Sauce
17.		Veal Chops	Candied Sweet Potatoes	Creamed Dried Corn	Pepper Hash	Marshmallow Whip
18.		Mixed Grill: Lamb Chops, Kidney, Bacon	Mashed Potatoes	Buttered Lima Beans	Beet Relish	Peach Tapioca
19.		Salmon Croquettes	Baked Stuffed Potatoes	Dutch Spinach	Celery, Olives	Cottage Pudding
20.		Meat Loaf With Mushroom Gravy	Escalloped Potatoes	Buttered Green Beans	Sweet Relish	Pumpkin Pie
21.		Roast Beef	Riced Potatoes	Buttered Beets	Beatrice Salad	Coconut Custard
22.	Tomato Juice	Baked Ham	Candied Sweet Potatoes	Buttered Green Lima Beans	Pineapple Lime Salad	Vanilla Ice Cream
23.		Baked Veal Pie		Buttered Carrot Rings	Salad Greens	Caramel Custard
24.		Hamburg Roll	Buttered Rice	Escalloped Tomatoes	Celery	Chocolate Pudding
25.	Cranberry Cocktail	Roast Turkey With Dressing	Mashed Potatoes	Buttered Asparagus, Baby Onions	Gingerale Fruit Salad	Ice Cream, Candy, Nuts
26.		Fillet of Perch	Sautéed Noodles	Spinach Timbales	Prune-Cheese Salad	Lemon Sherbet
27.		Broiled Sirloin Steak	Baked Potatoes	Frosted Buttered Asparagus	Cabbage Salad	Mince Pie
28.		Grilled Ham	Baked Macaroni and Cheese	Buttered Parsnips	Quick Coleslaw	Butterscotch Pudding
29.	Grapefruit Cocktail	Fricassee of Chicken	Candied Sweet Potatoes	Buttered New Peas and Carrots	Celery, Olives, Pickles	Almond Ice Cream
30.		Breaded Veal Cutlets	Mashed Potatoes	Succotash	Celery Curls	Lemon Meringue Pie
31.	Chicken Noodle Soup		Creamed Asparagus on Toast		Sunset Salad	Fruit Gelatin With Whipped Cream

Recipes will be supplied on request by The Modern Hospital, Chicago.

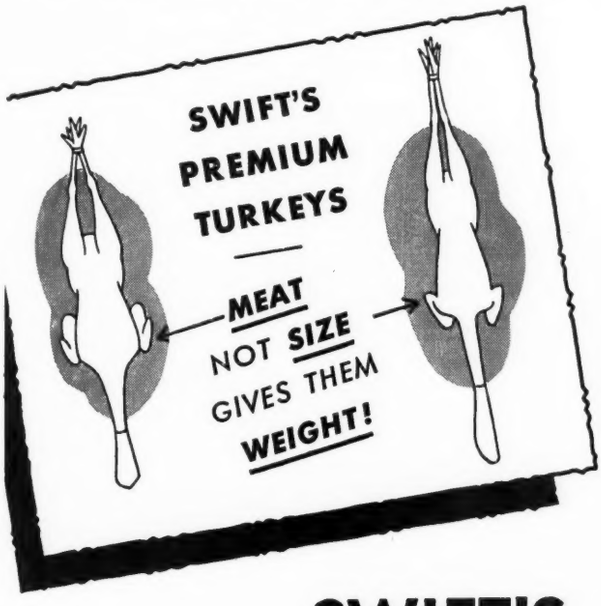
PLUMP, MEAT-HEAVY TURKEYS

. . . TENDER AND DELICIOUS!

. . . MORE SERVINGS PER POUND!



This seal is your guarantee of quality →



Specially selected from quality flocks, Swift's Premium Turkeys are scientifically fed to make them fat and heavy . . . juicy and tender. Critical, expert inspection and careful grading assure you that every turkey bearing the Swift's Premium tag is the very finest obtainable . . . the same top quality that has made the Swift's Premium name famous on ham, bacon and fresh meats.

Very important to you, these finer turkeys yield a *maximum number of servings per bird.* They have extra plump breasts with lots of tender white meat and heavy thighs and drumsticks for plenty of juicy dark meat. Their meat—not their size—gives them weight!

Buy turkeys the easy, sure way . . . buy *Swift's Premium Turkeys!* Order from your Swift salesman, or write direct to Swift & Company, Chicago.

SWIFT'S PREMIUM TURKEYS

"The pick of the Flocks"

Maintenance of Windows

ELIZABETH KINGSFORD, R.N.
Executive Housekeeper, Alameda County Hospital, Oakland, Calif.

THE cost of window maintenance is dependent to a considerable extent on the construction of the windows and their accessories. Unfortunately, the executive housekeeper has little opportunity to exercise her knowledge or preferences as primary construction has frequently been completed before she assumes her duties or is in a position to make recommendations.

Window construction should permit complete maintenance of exterior and interior sash in one operation. It will be an economy in maintenance if the windows are standardized as to size, thus eliminating the carrying of a large stock of various sized shades and other accessories for repair and replacement. There will, of course, be necessary exceptions to this rule, as special design and construction are sometimes necessary in order to meet a specific need.

An example of special window design is found in the psychopathic ward where in recent years strong window construction has eliminated the bad psychological effect on patients caused by guards and bars. The operating rooms, too, need special installations, dependent upon the design, size and location of the surgical department. Natural lighting and ventilation are today secondary considerations in the surgery since the advent of air conditioning and improved artificial surgical lighting facilities.

In selecting window hardware, choice of solid bronze or steel with a baked finish will result in limited maintenance and in little or no replacements or repairs.

Indoor hardware must be kept well oiled and polished; the use of metal lacquer will eliminate the need for too frequent polishing. An alert window washer can be of much assistance in reducing the repair load by checking all fixtures during the washing process and by reporting minor weaknesses, such as loose bolts, before damage or destruction has taken place.

Painted window frames and sills need careful maintenance and protection. The elimination of strong alkali cleansers and the substitution of one of the many good paint renovators that act as soil emulsifiers will do much toward reducing maintenance costs.

Exposure to storms and sunlight can do considerable damage to painted surfaces. The nursing and housekeeping personnel should be instructed to close the windows during rainy weather and to draw the shades, when possible, during the height of the sun's rays.

In the stress of more urgent demands, the housekeeper may feel inclined to shelve window care for the less harried future. With the advent of winter, however, details of window maintenance bear attention; Miss Kingsford's comments will be helpful in this regard

In painting outside sills constructed of new wood, a proper prime coat must be used to prevent shrinking and warping. Painting should not be done in periods of extreme cold or heat; avoid exterior painting when the temperature is 110° F. or below 60° F. If the area to be painted is damp or not of seasoned lumber the paint will peel.

Refinishing old surfaces requires proper cleaning and drying. Removal of oil and grease is essential or blistering and peeling will result. Old paint on exterior surfaces can be removed by the torch method or by scraping. The use of a paint remover is difficult and expensive and is almost impossible on a vertical surface, such as the window trim.

In the case of metal windows, it is important to look for signs of rust. Immediately upon being found, the rust spot should be completely scraped off and paint applied.

Either wood or metal windows should be painted at about three year intervals.

When windows have window cleaners' bolts, these bolts should be inspected from time to time to be sure that they are firmly embedded either in the masonry or in the window frame. Window cleaners' safety belts need frequent testing.

The functions of window shades are to shut out light, to tone down light, to give privacy and to decorate.

Shades should be so hung as to prevent their injury or destruction when the window is open and the wind is blowing. The use of the double roller shade, which is hung at the center of the window, is recommended for most institutions. Two shades are required for each window and care must be taken that no light crack shows between them.

When completely drawn, the shade should cover the entire window; an extra 12 inches should always be allowed on the length to meet this requirement and there should be an extra inch on either side to cover the casing so that no light will penetrate at the edges.

Tan or buff is the favored color for general usage. A heavy grade double-faced black shade is needed for use in the operating rooms and x-ray departments.

Brackets and rollers need to be well constructed and of good quality

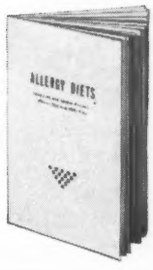
Quick Answers
to 3 common diet Questions

Where can I get a REAL WHOLE GRAIN bread?

Ry-Krisp is an honest-to-goodness whole grain bread made simply of rye, water and salt. Delicious. Wholesome. Yields 7 International Units vitamin B_1 per 6.5 gram wafer. A good source of iron, copper, phosphorus, manganese. Complete analysis and free samples sent on request.

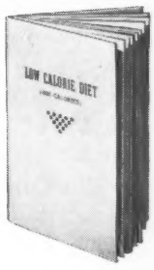
What bread can I eat if I have a WHEAT ALLERGY?

Allergy Diet book lists allowed and forbidden foods—gives tested recipes for wheat, milk and egg-free diets, and food diary for keeping daily food record. Ry-Krisp indicated as bread because it contains no wheat, milk or eggs. Supply of Allergy Diets free on request.

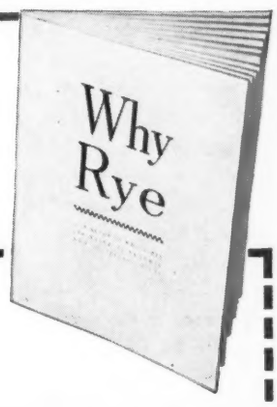


What should I eat to LOSE WEIGHT?

Ry-Krisp low-calorie diets permit gradual loss of weight. Supply all dietary essentials with possible exception of vitamin D. Ry-Krisp indicated as bread because it has a high hunger-satisfying value, yet each wafer yields only 23 calories. Diets free on request.



Free! handy reference book on whole rye . . .



RALSTON PURINA COMPANY
961A Checkerboard Square, St. Louis, Mo.

Please send free copy "Why Rye" and____copies Low-Calorie Diets, ____Allergy Diets and samples of Ry-Krisp. No cost or obligation.

*Name*_____

*Address*_____

*City*_____ *State*_____

Valuable 16-page book on whole rye and its value in normal and special diets. Compiled by Ralston Research Laboratories for the profession. Use coupon.

as frail brackets and springs are frequently the cause of annoying shade trouble.

For the shade itself a good quality of cotton fabric is recommended. It must be waterproof, sunproof, washable and color fast. With reasonable care, a high grade of shade should last over a period of years.

A sample specification for a window shade is as follows:

"First grade, 54 inches wide. Cloth shall be unfilled cambric not less than 72 threads per inch, double processed by hand painting, with highest quality oleoresinous and pigment material impregnating all threads, making a flexible sealed coating and preventing deterioration of the cotton fabric. Tint shall go clear through the shade cloth. Finished shade shall be waterproof, sunproof and noncracking. Shade cloth shall be free from imperfections in manufacture and from defects in appearance and serviceability. When issuing bid on brand number, specify brand desired or its equal in quality or utility. Submit sample of 1 square foot if submitting other than specified brand."

Venetian blinds have decorative value as well as utilitarian purposes. They should be accurately measured so that light will not enter at the sides. The material may be wood, usually cedar of good quality, or metal. The tapes should not shrink or stretch and should be sunproof and color fast. Ties should be so placed that the slats are accurately spaced.

Ease of operation also is essential so that the blind will remain in the position desired; the use of an automatic cord lock will meet this requirement. A cord equalizer assures equal falling and rising in a horizontal position and should be deeply grooved to prevent the cords from slipping.

When it comes to selecting window screens it is important to choose the type to meet local needs. Copper, bronze and nickel chrome are best suited for hospital use. Deterioration of wire screen near the ocean is rapid owing to fog deposits. Corrosion is hastened by the action of the acid in soot and by chemical fumes in industrial centers. Therefore, consider local conditions carefully before placing an order for screens.

The screen needs to be strong enough to avoid its being torn or its bulging by the usual accidents and shocks. Mesh and thickness are factors to be considered, together with tensile strength, in purchasing window screen.

Frames may be of wood or metal. If wood is the desired material it should be well seasoned, first grade, to withstand weathering. Corners and joints must be reenforced. Metal frames should be welded at the corners. All screens should be so attached that they can be easily moved by the window washers.

To Reduce Waste

WHAT can be done to control waste and what specific forms of waste are most prevalent in the housekeeping department? This question is constantly being put to executive housekeepers all over the country to provide an interchange of thought on this always present problem. This month it is Alice M. Eldridge of Fairmount Hospital of Alameda County, San Leandro, Calif., who expresses her opinion.

"The greatest loss in the housekeeping department is linen, I believe. The ideal linen system has not yet been worked out, but each executive housekeeper should strive to develop a linen system for the institution in which she is employed which is not too complicated but by which she can check her linen at any time. Leave no loopholes in the system for the linen to escape. Do not expect the nursing department to carry this load.

"Make the executive housekeeper responsible and then give her all the backing necessary. To do this, the laundry should be under her direction. The life of linen depends upon its use and abuse. If laundry formulas are correct and if the standard allowance of linen is generous enough to allow the linen to rest, it will wear much longer. Take linen inventories. Work closely with the nursing department on all linen problems.

"Time and energy are wasted by poor work plans. The work of every employe should be studied in detail and then outlined to avoid unnecessary steps, retracing of steps and repetition of work. Supply employes with proper equipment to avoid time wasted in running back and forth gathering tools.

"We instruct by written job analysis, giving a copy to the novice and explaining it to him, watching his procedure of work, correcting and advising on the job; further instruction may be accomplished by posting a copy of the work detail at each janitor's work base where he can refer to it with ease. Never reprimand an employe in front of another employe or the patients; if one of my employes must be corrected, I have him come to my office where we may talk quietly. Department meetings are held regularly at which we take up questions of institutional policy, new orders, new ideas.

"There is waste in cleaning materials. Standardize. Be explicit in the use of all cleaners. Teach, demonstrate and check continuously so there can be no waste. Keep records of amounts used so you may know where the leaks are and can find a means to eliminate them as quickly as possible.

"Another place for saving is in the use of good paint. If paint of good quality is used, the walls and woodwork can be washed several times before repainting.

"The employes must be made to feel that they are a necessary part of the plan to take care of the sick. They should be treated as we should like to be treated by them if we were in their place. Above all, we must not nag or irritate them.

"We try to respect and understand the position of other employes, remembering that they have their problems as well as we. If they feel that we are trying to be of help to them and that we wish to help in whatever way we can, they will cooperate. Most friction comes from lack of understanding. In fact, we must all understand that in order to operate smoothly we are all necessary—from the man tending the incinerator to the superintendent."

For Boys and Girls in their teens

Dole Pineapple Juice is a good source of Thiamin and Ascorbic Acid

Authoritative analyses and assays accepted by the Council on Foods and Nutrition of the American Medical Association show that a 6-oz. serving of Dole Pineapple Juice (approximately 100 calories) contains 240 I. U. of Vitamin C (Ascorbic Acid) and 100 I. U. of Vitamin B_1 (Thiamin).

Notice the chart below. It indicates what Dole Pineapple Juice contributes to the daily allowances for specific nutrients recommended by the Committee on Food and Nutrition of the National Research Council. The left-hand column gives recommended amounts. The right-hand column represents the percentage of the recommendations found in a 6-oz. serving of Dole Pineapple Juice.

Dole Pineapple Juice is also a good source of Vitamins B_1 and C for men and women. It is tempting to healthy appetites and easily assimilated. It is the true, undiluted juice of sun-ripened pineapples and a satisfactory addition to the fruit juice diet.

Percentage contributed to daily recommendations by a 6-oz. serving of Dole Pineapple Juice	THIAMIN B_1		ASCORBIC ACID C	
	Rec. N.R.C. Mgs.	DOLE	Rec. N.R.C. Mgs.	DOLE
Girls 13 - 15 Years	1.4	22%	80.	15%
Girls 16 - 20 Years	1.2	25%	80.	15%
Boys 13 - 15 Years	1.6	19%	90.	13%
Boys 16 - 20 Years	2.0	15%	100.	12%

DOLE Hawaiian Pineapple Juice FROM HAWAII U. S. A.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

How to Take a Usage Inventory

ROBERT E. CHURCH
Pharmacist, Blodgett Memorial Hospital, Grand Rapids, Mich.

AN ANNUAL inventory is considered good business practice. This procedure is no less important for the efficient operation of a hospital pharmacy. However, this annual inventory alone is not sufficient if the hospital pharmacist does nothing but speculate on the facts and figures that he has obtained.

Notwithstanding the professional obligations of the pharmacist, he has another important obligation to his institution in keeping his armamentarium of drugs fresh and up to date with progressive medical practice. By means of a usage inventory he can fulfill this obligation by closely observing and weeding out those medications that have fallen into disuse.

By means of a usage inventory those drugs and preparations that are no longer prescribed or seldom used are returned to the manufacturer for credit, especially when the preparation has an expiration date. Just as outdated biologicals are returned at the end of the expiration date so should many medications be weeded out after they have served their usefulness.

In many hospitals the prescribing of medications is confined as closely as possible to the hospital formulary; however, with the present rapid changes in drug therapy it is sometimes impossible to keep within this confinement and I have found, in my hospital experience, that new drugs are ordered for patients before the pharmacy committee has had time to consider them for inclusion in the formulary. Especially has this been true with such newer drugs as those of the sulfonamide group.

In putting a usage inventory into effect, several factors must be kept in mind: (1) nature and stability of the product; (2) length of time needed to procure a seldom prescribed substance; (3) proper storage facilities, especially with respect to refrigerator space and moderately cool storage rooms, and (4) price of the product.

Fortunately, our hospital is located in a city containing a large professional pharmacy with twenty-four hour service and we are able to procure many infrequently prescribed medications from this pharmacy. On the other hand, it should not be too much trouble for the pharmacist who is not so fortunately located to suggest to the attending physician some other comparable product, if the prescribed medication is not kept in the hospital pharmacy. I have always found physicians cooperative when these occasions arose.

Considering the foregoing factors with regard to medicinals other than those manufactured by the hospital pharmacy, I find that it is a good policy not to keep any unused preparation longer than a year. In the first place, a year's time should be sufficient for a medicinal product to prove its worth; we must bear in mind that we are particularly interested in seeing that the hospital's money is not tied up in dead timber. In the second place, the longer some materials are kept the less credit will be obtained from them when returned. Many things do not improve with age and this holds true for most medications.

In putting a usage inventory into effect, use is made of permanent inventory cards, which are individual records of date, order number, source of supply, amount and cost of each item carried in our pharmaceutical stock. Every six months these cards are checked and note is made of the preparations that are not being prescribed. If at the end of a year these are still unused, all unbroken packages are returned to the manufacturer or source of supply for credit. An exception may be made in the case of hermetically sealed ampules, inasmuch as these are preparations that may be needed in a hurry, and needed badly; for example, sodium formaldehyde sulfoxylate, used in mercury poisoning. If ampules are stored under proper temperature conditions, there is no reason why 99 per cent of them should not remain stable.

If a usage inventory is made regularly as suggested, it is possible to keep fresh medications; in return, the hospital can benefit by the credit obtained for returned preparations. During the first year of my stay at Blodgett Memorial Hospital materials amounting in value to nearly $400 were returned for credit.

To be sure, if a usage inventory is made regularly such large amounts will not be realized yearly, but over a period of years the value of these credits should amount to quite a sum.

Briefly, the value to the hospital of a usage inventory means savings to the institution, relatively fresh medications and chemicals and a smaller but more workable armamentarium for the physician.

Amp. Amytal Sod. 0.25 gm. (3¾ gr.) (Lilly)

DATE	*ORDER NO.*	*FIRM*	*QUAN.*	*UNIT*	*COST*	*UNIT COST*	*SELL*
4/25/41	14,830	M.A.	6	0.25	$3.60	$0.60	$0.80
5/ 5/41	14,838	M.A.	10	...	6.00	.60	.80
5 /9/41	14,431	H.P.	10	...	6.00	.60	.80

Sample card used in the inventory system in effect at Blodgett Memorial Hospital.

"SEE YOUR DOCTOR." Reproduced below is Number 171 of a series of full-page advertisements published by Parke, Davis & Co. in the interest of the medical profession. This "See Your Doctor" campaign has been running in *The Saturday Evening Post* and other leading magazines for thirteen years.

The man who nearly died . . . from a few kind words

BEYOND THAT DOOR lies a very sick man. True, his doctor says he is going to pull through. But he has come mighty close to paying a tragic price for a few words of free advice from a well-meaning friend.

When he complained of a nagging pain in his abdomen, his friend said: "You've probably eaten something that's poisoned you. Here's what *I'd* do . . ."

So he promptly followed his friend's suggestion and took a cathartic. And in a matter of hours he was being rushed by ambulance to the hospital . . . with a ruptured appendix.

His friend, of course, had acted from the kindest of motives. But he didn't know that an abdominal pain might mean acute appendicitis, in which case a cathartic should never be taken.

Unfortunately, appendicitis is only one of many illnesses where amateur medical advice can result in tragedy. Yet, human nature being what it is, many people just can't resist the temptation to offer advice when a friend is sick.

Intelligent medical treatment depends upon various factors which only a physician is qualified to evaluate. When something seems wrong with you, it is the part of wisdom to observe this common-sense rule: Take a friend's advice about buying a radio, a car, or even a home if you wish; but don't let him advise you about your health.

Don't let a friend who *means* well tell you how to *get* well. To get well, and *keep* well, the man to see is your physician.

PARKE, DAVIS & COMPANY
Detroit, Michigan
Seventy-five years of service to medicine and pharmacy

SEE YOUR DOCTOR

Equipping the Small Department

SISTER MARY LOYOLA

Pharmacist, St. John's Hospital, Joplin, Mo.

IN PLANNING and equipping the pharmacy in a small hospital the first and most important thing to consider is the location. The pharmacy should be easily accessible to all departments.

Light and ventilation are important items to be considered, as the pharmacist spends long hours in this room.

The walls and ceiling should be light and the floor covering of some composition that is easily kept clean. Tile or inlaid linoleum answers the purpose very well.

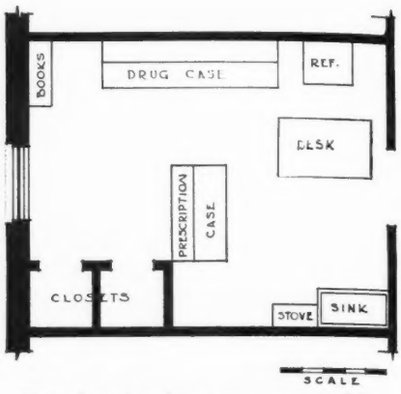
Furnishings must be planned to conserve space. The essential pieces of furniture are a prescription case, drug cabinet, refrigerator, source of heat (gas plate), sink, bookcase, desk, typewriter and storage presses built in with plenty of shelves of various depths and strong locks on the doors for the storage of narcotics and potent drugs.

For convenience and to save time the stock in our pharmacy is indexed. The room is divided into sections. Chemicals, ampules, ointments and tinctures are arranged alphabetically from left to right. Everything is indexed before it is put in stock.

In a hospital pharmacy, much of the medicine dispensed is in the single dose. The nurse comes to the dispensing window and writes her order for the medicine. The pharmacist posts all of the charges to the patient's account in a book which is set aside for that purpose. This facilitates the work of the bookkeeper.

It is important to have regular hours and a regular course of work in the pharmacy. In this way much more can be accomplished and nothing will be forgotten in the day's routine.

At St. John's Hospital, Joplin, Mo., Saturday is set aside for the filling of orders for the floors and other departments. The baskets with their lists are sent to the pharmacy early and are disposed of in a short time. This is also the day the pharmacy gets a thorough cleaning, stock is straightened and orders are placed for supplies that are running low.



Plot plan showing arrangement of the pharmacy at St. Joseph's Hospital.

As more and more new drugs are coming into use, it is almost impossible to keep up with them all. To compensate for this we keep an

(*Continued on page* 98)

Minimum Essentials for Compounding and Dispensing*

1 prescription balance kept in good workable condition and sensitive to 1/20 gr. or 3 mgm.
1 balance for weighing larger quantities, *e.g.* lb.
1 set of apothecaries' weights, ½ gr. to 1 oz.
1 set of metric weights, 10 to 50 mgm.
1 set of at least six graduates, 60 min. to 1 qt.
1 set of at least four graduates, 5 to 1000 cc.
2 wedgwood mortars and pestles, large and small
2 glass mortars and pestles, large and small
Steel spatulas.
1 rubber or composition spatula
Source of heat at the prescription counter
Refrigerated storage space for biologicals
1 pill tile
1 pill roller
1 pill finisher
1 water bath
1 set of funnels, 3 to 6 in. in diameter
1 ring stand or funnel support
1 percolator
3 stirring rods
Filter paper, absorbent cotton, gauze and shredded asbestos or glass wool
3 flasks, 100 to 1000 cc., 500 cc.
2 evaporating dishes, 4 and 8 in.
All of standard sizes of empty capsules
Powder papers, wax and plain
All standard sizes of prescription bottles with good grade corks or other closures
Supply of auxiliary labels: shake, poison, external, etc.
All standard sizes of ointment jars
Ointment tubes, small sizes, assorted tips
1 moderately fine sieve
Drugs and chemicals, U.S.P. grade
Distilled water available at all times
1 modern filing system for prescriptions
Copies of the latest editions of U.S.P., N.F. and N.N.R.
Copy of the latest regulations on the dispensing of alcohol
Copy of the latest regulations on the dispensing of narcotics
1 carefully kept poison register
1 carefully kept exempt narcotic record
1 copy of the A.Ph. A. Code of Ethics

*From "Suggestions for an Accredited Pharmacy" by Dean H. C. Newton, *Northwestern Druggist* February 1932, pp. 13-14.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.

Emergency Drugs

Since our first discussion of this topic in the July issue several noteworthy contributions and additions have been made to the field of drug therapy, not the least of which concerns again that dramatic group of chemical "lifesavers" known as the sulfonamides.

Sulfadiazine

• Most recent of the sulfonamides to gain thorough consideration, trial and recognition by laboratory and clinical investigators is sulfadiazine. Although of real value in various types of infections, sulfadiazine has special virtue in the early treatment of pneumococcic pneumonia as recently reported by Dowling, Hartman and co-workers in Washington, D. C.

If present reports are amply confirmed by other investigators, sulfadiazine may well be the sulfonamide of first choice in this infection since it has several outstanding advantages when compared with sulfapyridine, sulfathiazole or with the sodium salts of the latter. These advantages include more rapid absorption from the gastrointestinal tract; a higher, effective blood level which is often more rapidly attained; slower excretion with a lessened incidence of calcretion deposition at the kidney, and less nausea and vomiting than with other sulfonamides. When vomiting does appear, Dowling et al. believe it to be less severe in nature and not intensive enough to preclude further oral administration of the drug, should this be necessary.

Other toxic manifestations characteristic of sulfonamide therapy should be anticipated, especially that of leukopenia, because of the amidopyrimidine component of sulfadiazine (2-sulfanilamidopyrimidine). Dowling reports an incidence of 2.2 per cent. Although sulfadiazine seems to be another successful step in our long trek toward the goal of attaining the "ideal sulfonamide," next year may find us even more enthusiastic about some more recently developed "cousin" of the sulfonamide family.

Analgetics

• Trichlorethylene is a highly volatile liquid whose value as a pain killer in "facial neuralgia" (tic douloureux) was rather accidentally discovered when an observing physician reported the relief of this type of pain in a worker who was exposed to this chemical in his daily factory routine where it was used as a fat and varnish solvent. Repeated successfully on other patients, introduction of this "emergency drug" into medical practice soon followed.

Twenty or thirty drops placed upon a handkerchief and inhaled as needed affords excellent relief for months in some patients, without severe consequences. Administration in the prone position obviates accidents that might occur subsequent to slight fall of blood pressure and dizziness.

Administration of trichlorethylene has been greatly facilitated by the introduction of a durable atomizer, especially constructed by Jackson of Cincinnati. The leakproof flask is placed at the patient's bedside and the one-piece unit comprising the mask with bulb attached is placed over the nose and mouth while the patient presses the bulb to gain relief. Should drowsiness proceed to unconsciousness, nature's protective mechanism (sleep) of releasing the contractile powers of the hand and arm muscles prevents continued atomization with consequent overdosage; hence, wakefulness merely follows sleep until pain is lost, obviating further treatment. The appeal of this mechanical device is obvious when one further debates the desirability of self-induced obstetrical analgesia or relief of spasmodic pain associated with other areas.

Aminophyllin

• The value of this theophylline compound has been long and arduously debated. Those investigators who are not too convinced of its efficacy in coronary disease include Gold and his co-workers of New York City, but arduous proponents of the drug can be found in LeRoy's clinic at Chicago. The use of this drug in coronary disease entails emergency procedures as well as chronic or continued treatment but a genuinely justifiable emergency indication for aminophyllin is in the asthmatic patient who has become resistant or nonresponsive to the usual relaxing effect which epinephrine elicits in the bronchioles.

This type of "epinephrine-fast" patient can sometimes gain dramatic relief, as Lamson and Bacon of Los Angeles and others have demonstrated, by slow intravenous instillation of 0.080 gm. or more of aminophyllin, but remarkable relief in every case should not be anticipated. Peculiarly, once this type of asthma has been relieved by aminophyllin, the patient frequently again responds in the normal manner to epinephrine in succeeding asthmatic bouts.

Spinal Anesthesia

• In lieu of supplementing the waning action of procaine in spinal action by some volatile anesthetic, such as ether, nitrous oxide, ethylene or cyclopropane, Lemmon of Philadelphia has cleverly developed the technic that permits retention of a German silver, pliable, blunt-pointed needle within the subdural reservoir, attached by means of a narrow rubber tube to a graduated syringe containing procaine hydrochloride. Assurance of flow, when desired, and prevention of neural damage are facilitated by a properly constructed segmented mattress and operating table. As spinal anesthesia wanes, injection of from 3 to 5 mgm. of procaine hydrochloride reinduces anesthesia within from fifteen to thirty seconds; this prevails for several minutes. This emergency treatment affords well-regulated or controlled anesthesia without necessitating introduction of the objections associated with inhalation anesthesia, which was originally discriminated against in favor of spinal anesthesia for the case under consideration.—F. F. Yonkman, M.D.

(*Continued from page* 96)

up-to-date reference file where data pertaining to the new drugs are placed. When time permits this material is looked over carefully, and when an inquiry is made concerning some new drug an intelligent answer can be given.

It is well to be a subscriber to two or more periodicals, such as the *Journal of the American Pharmaceutical Association, American Professional Pharmacist* and the state publications.

News in Review

President to Recommend Expansion of Present Social Security Program

RUTH HILL ZIMMERMAN
Washington Correspondent, The MODERN HOSPITAL

WASHINGTON, D. C. — Recommendations for the inclusion of both temporary and permanent disability insurance in the social security program may be made in a special message which President Roosevelt is expected to submit to Congress before long.

These two features have been recommended by the Social Security Board and are known to be among the provisions being considered by the executive office.

President Roosevelt told a press conference early in October that he intended recommending broad expansion of the coverage of the existing program. Most important of the new groups to be added are farm operators, agricultural workers, domestics and workers in nonprofit institutions (such as hospitals). The president estimated that if his recommendations were followed the number of persons covered by social security provisions would be increased from 40,000,000 to 80,000,000. He stated that the increase in groups taxed would be beneficial in deterring inflation now and, later, in guarding against deflation.

At the Federal Security Agency, it was indicated that a permanent disability insurance plan might be associated with the present old age and survivors' insurance without increasing the tax rate at present. Ultimately, of course, the cost would have to be met but, for a period of years, until the full impact of the cost of the program was felt, it might be financed out of the margin in the old age and survivors' tax receipts. Temporary disability insurance might be associated with unemployment compensation plans or might be modeled upon that program.

Washington Institutions Seeking Alleviation of Overcrowded Facilities

WASHINGTON, D. C.—Overcrowding of Washington, D.C., hospitals has resulted in the suggestion by Dr. George C. Ruhland, district health officer, that "whenever possible" women should bear their babies at home to relieve the congestion of maternity wards.

The Instructive Visiting Nurses' Association reported at its first fall meeting in mid-October that Doctor Ruhland's suggestion has evidently been followed and that Instructive Visiting Nurses are caring for a number of women not delivered in the hospitals.

Doctor Ruhland pointed out in a recent statement that, although the District of Columbia has a high rate of hospital beds (193.9 per 10,000 population in 1939), the figures are misleading. More than 9400 of the 13,568 beds are in four governmental hospitals (St. Elizabeth's, United States Naval, Veterans' Administration and Walter Reed hospitals) which supply a nationwide need and serve the District of Columbia only in a limited way.

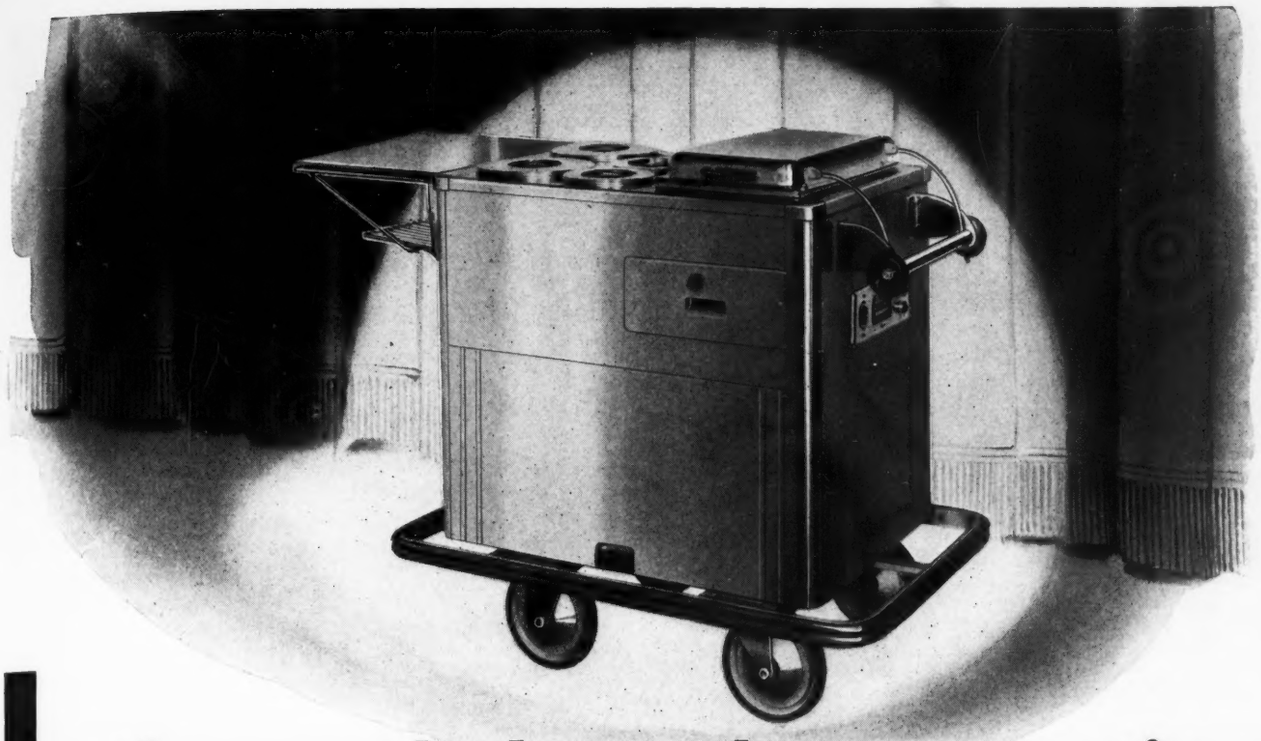
The situation in the District of Columbia is further complicated by great use of Washington facilities by residents of near-by suburban communities in Maryland and Virginia. The health department, recognizing the drain on Washington facilities resulting from out-of-the-city use, is urging the establishment and expansion of community hospitals.

Rising Hospital and Clinic Costs Is Subject of Study

The Health Security Administration of Washington, D.C., the agency that administers the Community Chest share of hospital payments, is engaged in a continuing study of rising hospital and clinic costs. The administration plans to make public its findings from time to time as a guard against both profiteering and misunderstanding of justified charge increases, according to Ross Garrett, head of the Health Security Administration.

Although the study thus far has revealed an increase of approximately 11 per cent in operation costs over a two month period, hospital fees have not advanced appreciably as yet. Mr. Garrett said that his agency was attempting to persuade hospitals to increase their fees gradually as costs move upward rather than to hold back now and jolt the public with larger increases later.

On the other hand, Mr. Garrett is quoted as stating that there must be no profiteering in medical care. Hospitals must not be permitted to raise charges merely because there is a shortage of beds.



In the spotlight at the convention

Ideal FOOD CONVEYOR SYSTEMS

THE MODERN EQUIPMENT FOR HOSPITAL FOOD SERVICE

New Ideal Series 1000 includes many models which assure ease and speed in distribution of perfectly served foods.

● Conventioners were interested and thrilled by the Ideal exhibit because it revealed such startling advancements in the engineering and development of hospital food conveyors. They saw a line that embodies new, exclusive, valuable basic features in units available in an almost infinite variety of materials, priced to fit every budget. Ideal alone makes available to every hospital an advanced, safe, approved, guaranteed unit that meets the most exacting food service need under any and all conditions of use.

New Ideal Series 5000 tray conveyors, with and without electric heat as desired, are amazingly light in weight and easy to handle.

MANUFACTURED BY

THE SWARTZBAUGH MFG. CO. . . TOLEDO, OHIO . . U.S.A.

DISTRIBUTED BY

THE COLSON CORPORATION, ELYRIA, OHIO

In California: **The Colson Equipment & Supply Company, Los Angeles and San Francisco**

In Canada: **The Canadian Fairbanks-Morse Co.**

New Ideal Series 3000 meets a widespread demand for an outdoor service unit that permits noiseless, easy locomotion over uneven surfaces. The large wheels are equipped with pneumatic tires having standard type inner tubes.

New Ideal Series 4000 presents compact, light and inexpensive food conveyor service for the small hospital or the larger institution requiring good food service to a few patients in an isolated or special section.

Additional Hospital Construction Authorized Under Lanham Act

WASHINGTON, D. C.—The construction of two new hospitals and of additions to seven others was among the projects authorized during last month under the Defense Public Works program. Four health centers and four health clinics, which are also projects coming within the scope of the Community Facilities (Lanham) Act, were approved. These 17 projects are in addition to five previously approved hospital expansion projects described in the October issue.

The recently authorized projects are as follows:

1. A 96 bed addition to the Monterey County Hospital at Salinas, Calif. This is federal construction and will cost $527,606.

2. A 112 bed isolation hospital, replacing an obsolete frame building, at Hartford County Hospital, Hartford, Conn. Of the $513,313 total cost for construction and equipment, $153,994 will be provided by a Defense Public Works grant and $359,319 by Hartford County.

3. At Tallahassee, Fla., a new 100 bed hospital to cost $400,000, including 18 beds for Negroes and quarters for the nursing staff. The city will provide $320,000 and the federal government $80,000 in the form of a grant. The present Tallahassee hospital is a 31 bed institution.

4. An addition to the Weymouth Hospital, South Weymouth, Mass., to provide 26 additional beds and 18 bassinets. The present hospital contains 74 beds. Of the $150,000 estimated cost, $110,000 will be a loan from the federal government and $40,000, a grant.

5. A new 37 bed hospital for the town of Sidney, N. Y. It will be federal construction and is to cost $133,000, including equipment.

6. Additions and alterations to transform the 35 bed hospital at Ilion, N. Y., into a 60 bed institution. The $159,748 total cost will be divided equally between a federal grant and funds supplied by the hospital.

7. A 60 bed addition to Dixie Hospital, Hampton, Va., to cost $201,700 of which $180,000 is a federal grant and $21,700 is to be supplied by the applicant, the Hampton Training School for Nurses.

8. Additions and alterations to the Riverside Hospital, Newport News, Va., to provide 50 additional beds, making a total of 102 beds. Of the estimated total cost of $298,120 for construction work and equipment, $200,000 is in the form of a federal grant and $98,120 will be supplied by the Newport News Hospital Association.

9. At Bremerton, Wash., where, it is estimated, the population in 1942 will be 30,000, double that reported in 1940, a new 148 bed hospital and nursing home, federally constructed and equipped, to be operated by the city under a long lease. At present Bremerton is served by one 14 bed hospital in the town and by a 60 bed county hospital, not included in the A. M. A. register, 13 miles from Bremerton.

The clinics and health centers authorized and their costs are: San Luis Obispo, Calif., $120,350; Anniston, Ala., $88,000; Vallejo, Calif., $32,498; Boise, Ida., $45,000; Henderson, Ky., $69,200; Fayetteville, N. C., $51,000; Columbia, S.C., $34,200, and Mineral Wells, Tex., $74,000.

Miami Beach Gets New Hospital

A $500,000 bond issue for erection of a 100 bed hospital has been authorized by the council of Miami Beach, Fla. Preliminary plans are under way. August Geiger, Russell Pancoast and L. M. Dixon are the architects and Charles F. Neergaard is the consultant.

Iowa to Conduct Two Day Institute in Administration

A two day institute in hospital administration is to be held at the University of Iowa Hospitals on November 5 and 6 in place of the regional meetings usually held by the Iowa Hospital Association. The Iowa Hospital Association requested the university to conduct this institute.

Speakers on Wednesday, November 5, will include Arthur O. Leff on "The Hospital and the Law," Dr. E. L. DeGowin on "Use of Stored Blood in Transfusions," Lois B. Corder and Mrs. Eloise January on "Isolation Technic," Robert E. Neff on "Relationships of the University Hospitals With Hospitals and Other Health and Social Agencies of Iowa," Ralph M. Barnes on "Time and Motion Studies" and Dr. Stuart Cullen on "Anesthesia Explosion Hazards." A dinner in the evening will be addressed by Virgil M. Hancher, president of the university, and Dr. E. M. MacEwen, dean of the college of medicine.

On Thursday there will be a round table led by Richard J. Conner with the following speakers: Verne A. Pangborn on "Present Status of Affairs in the Supply Field," Harold A. Smith on "Public Relations Program of a Hospital," Dr. Kate Daum on "Foods," Mrs. Edith H. Kelley on "Personnel Records, Timekeeping and Payroll," Dr. Wilbur R. Miller on "Care of the Mental Patient in General Hospitals," F. P. G. Lattner on reports of Hospital Service, Inc. of Iowa, Alvin Langehaug on the recent A.H.A. convention and F. M. Dawson on "Sanitary Features of Plumbing Equipment."

All of the speakers except Mr. Lattner and Mr. Langehaug are members of the faculty of the hospital staff of the university.

Bergen Pines Celebrates Anniversary

Twenty-five years of service to the community in providing hospital facilities for tuberculous and contagious disease patients was celebrated at Bergen Pines Hospital, Ridgeway, N. J., at an anniversary dinner attended by the board of free-holders and board of managers. On this occasion a testimonial was tendered to Dr. Joseph R. Morrow, superintendent, for the progress made since the inception of the institution in 1916. Suitable tributes were also accorded the public-spirited citizens of the community who have contributed to the work and the staff. A special souvenir of the occasion took the form of an attractively illustrated booklet describing the service that the hospital is rendering the public today.

Accepted for Administration Course

Nine students have been accepted for the graduate course in hospital administration of the University of Chicago School of Business for the current year. The students and their present academic degrees are: H. Allan Barth, B.S., University of Iowa, 1941; Ernest L. Bliss, B.B.A., Tulane, 1939; Charles E. Burbridge, B.A., Talladega College, 1931; Richard Highsmith, B.S., University of Southern California, 1937; Polly Hunt, B.A., Smith College, 1935; Sidney Liswood, B.B.A., C.C.N.Y., 1941; Andrew Pattulo, B.S.B.A., University of Nebraska, 1941; James L. Sexton, M.B.A., University of Southern California, 1940, and C. Robert Youngquist, A.B., Augustana College, 1940.

Springfield Fund Oversubscribed

Substantial oversubscription of its $1,100,000 building fund campaign has resulted in an enlargement of plans for the new building at Springfield Hospital, Springfield, Ill. The project, as now planned, will be eight stories high and the bed capacity will be 250, exclusive of nurseries. The Springfield campaign has resulted in the largest sum raised by voluntary subscription for hospital construction, in proportion to population, since 1930.

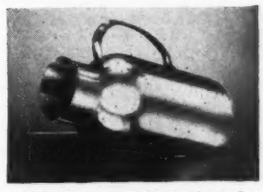
ACHILLES' HEEL . . .

Achilles was invulnerable in every part except his heel. It was there he received his mortal wound.

No detail can be overlooked in protecting the good reputation of your hospital. That is why leading hospitals from coast to coast insist upon Vollrath Enameled or Stainless Steel Ware. They know that their patients and physicians recognize Vollrath quality . . . Since 1874—sixty-seven years ago—Vollrath has steadfastly maintained its well-deserved leadership. Today, as always, Vollrath Hospital Ware is *designed* for beauty and utility and is *built* for long life. . . . We urge you to investigate *now!*

Enameled Forceps Jar

Enameled Pus Basin



Stainless Steel Male Urinal

Stainless Steel Measure

The Vollrath Co.

ESTABLISHED 1874

SHEBOYGAN • WISCONSIN

Welfare Agencies Report Expenditure of $64,000,000 for 1940 In-Patient Service

WASHINGTON, D. C.—Welfare agencies of 34 urban communities reporting to the Children's Bureau of the U. S. Department of Labor spent $64,068,839—almost 12 per cent of their assistance money—to provide hospital in-patient service in 1940. This expenditure was second only to that for relief and family welfare and did not include an almost equal expenditure made by the persons receiving service.

The survey included 34 cities of more than 100,000 population. Their total expenditures for health and welfare activities during 1940 amounted to $548,000,000 or approximately 5 per cent of the income of residents of the areas. This sum includes only the social contribution, that is, the governmental appropriations and community gifts.

More than half the expenditure for hospital in-patient service was provided by local public funds, totaling $36,862,781. The state appropriations provided $17,827,323, and the federal government, $246,638. Funds from private sources included $3,003,682 from income from endowments and $2,869,914 from community chests. Other private contributions totaled $2,220,124. Other private sources, not specified in the report, provided $1,038,377 for hospital in-patient service.

The per capita expenditure of welfare funds for hospital in-patient service averaged $3.72, about the same as the average for 1938 when a similar study was made by the Children's Bureau. However, there was an increase of 8 per cent in gross per capita expenditures from 1938 to 1940, resulting from an 18 per cent increase in per capita receipts from patients. The gross per capita expenditure averaged $7.24 in the 34 areas.

The Children's Bureau points out that this increase in patient expenditure is due to the development of hospital service plans as well as to improved economic conditions.

Clinic service resulted in an average expenditure of 50 cents per capita by social agencies in the 34 urban areas. The amount expended other than that received from patients was $8,708,007. Including payments of patients, the gross expenditure for clinic services was $10,240,554.

Cooper Hospital Opens New Building

Formal opening of the John Thompson Dorrance Memorial Building of Cooper Hospital, Camden, N. J., was held on October 16.

1941 Enrollment in Blue Cross Plans Largest Yet Reported

Nearly one half million additional persons were enrolled in approved Blue Cross plans during the period from July 1 to October 1, bringing the total enrollment for the 67 plans to 7,461,000 persons on the latter date. The growth of enrollment in plans was greater during the first nine months of 1941 than during the same period of any preceding year.

The largest growth during the past quarter for any single plan was that shown by Michigan Hospital Service, with a net increase of 57,000 participants. Other plans that added more than 10,000 to their net enrollment during the quarter were: Pittsburgh, 25,000; Chicago, 25,000; St. Louis, 23,000; Cleveland, 23,000; Philadelphia, 18,000; Cincinnati, 18,000; Newark, 18,000; Providence, 15,000; Boston, 15,000; Buffalo, 13,000; St. Paul, 13,000; Milwaukee, 11,000, and New York City, 11,000.

Revised Nursing Facts Published

The recently revised edition of "Facts About Nursing," published by the Nursing Information Bureau, New York City, contains new sections on military nursing, high schools and students in the United States and nursing legislation.

Eleven Naval Hospitals Now Under Construction, Secretary Knox Reveals

Eleven new naval hospitals with a total bed capacity of well over 2600 will soon be serving the U.S. Navy, according to a statement made by Secretary of the Navy Frank Knox on October 15. One of these hospitals is now in operation, eight are nearing completion and two are being planned.

The largest is the 500 bed hospital at the new U.S. Naval Center, Bethesda, Md. In addition, 14 dispensaries with hospital facilities providing more than 1600 beds have been planned and six are under construction. Also, seven existing naval hospitals are being expanded at a total cost of about $2,365,000 and two new mobile base hospitals have been authorized. Upon completion of this program the Navy will be operating nearly 30 large hospitals and two hospital ships.

A review of recent U.S. Army hospital construction projects reveals that 78 of them were reported during the twelve months ending October 1. There were also 10 Veterans' Administration hospital projects announced during this period, two projects for the U.S. Public Health Service and two for the U.S. Indian Office. Four unclassified projects, probably for the Army, were noted. The total expenditures authorized for federal hospital construction during the period was approximately $60,000,000, with an estimated average of nearly $600,000 per project.

Boston Host to Conference on Hospital Standardization

The national emergency as it affects hospitals will be the leading topic of discussion at the sessions of the twenty-fourth annual Hospital Standardization Conference sponsored by the American College of Surgeons, to be held in Boston from November 3 to 6 in connection with the annual Clinical Congress of the college.

Several hundred administrators, dietitians, technicians, nurses and other hospital personnel from all parts of the United States and Canada will attend the sessions, the program for which is under the direction of Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, aided by a local committee.

Among the speakers included in the program are Dr. Bert W. Caldwell, James A. Hamilton, Frank J. Walter, Dr. Evarts A. Graham, Dr. Dallas B. Phemister, Dr. Harold Ernheart, Raymond P. Sloan and Oliver G. Pratt.

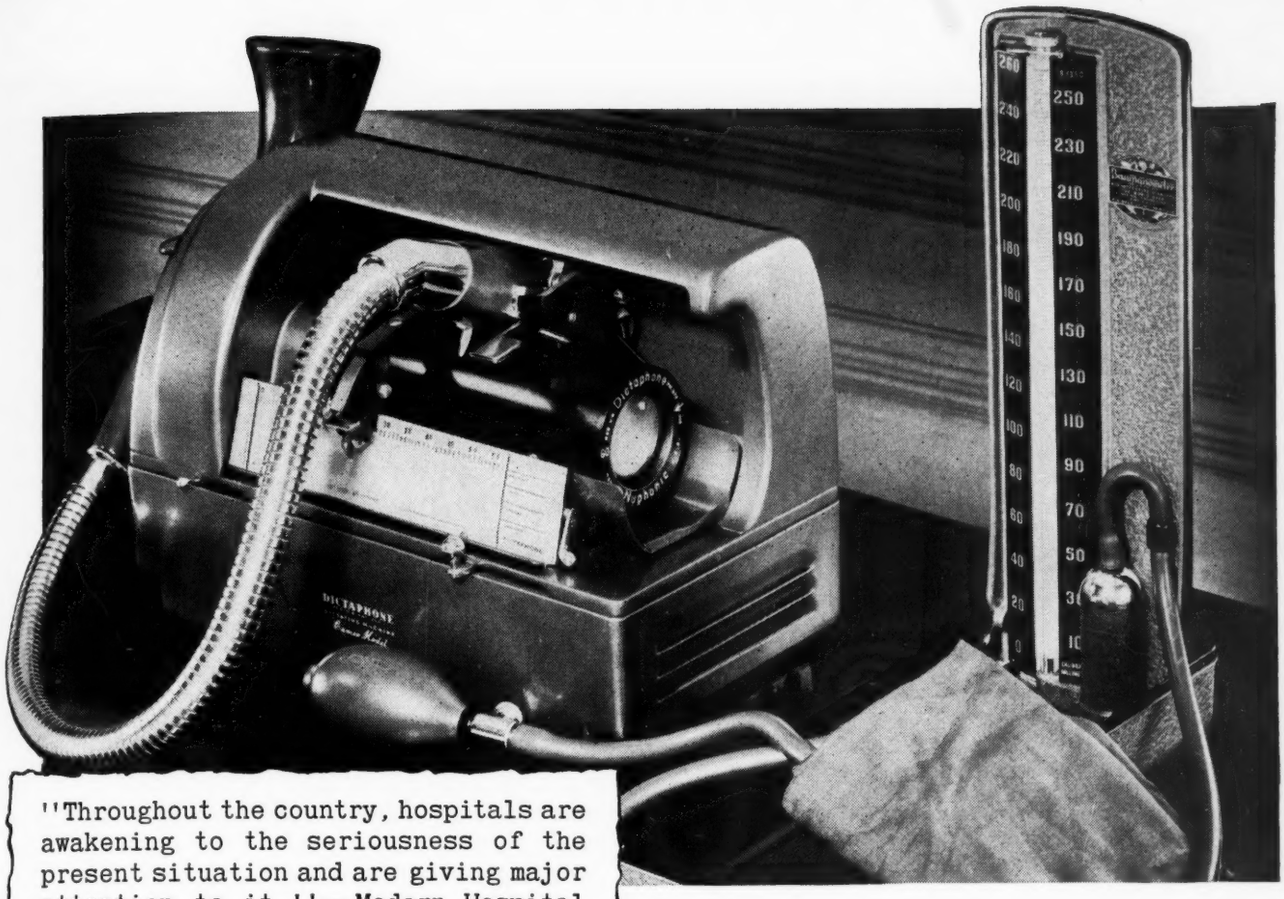
Foundation Lists Grants Accorded Nursing Schools

As part of its program of giving support to schools of nursing for public health training, the international health division of the Rockefeller Foundation lists the following grants in its annual report for 1940:

School of Nursing of the University of Toronto, $359,940; University of British Columbia Department of Nursing and Health, $7650; University of California, $7200; School of Nursing of Vanderbilt University, Nashville, Tenn., $700,000 endowment in addition to annual grants; Skidmore School of Nursing, Saratoga Springs, N.Y., $80,000; Santo Tomas Hospital School of Nursing, Panama, $34,000; Aarhus Postgraduate School for Nursing, Denmark, $20,430; School of Nursing, Bucharest, Rumania, $85,000.

Riverside Provides Beds for Tuberculous

Cornerstone laying ceremonies for a new tuberculosis pavilion which will add 150 beds to the present capacity of Riverside Hospital, New York City, were held October 20. Begun last March, the new three story pavilion, costing approximately $950,000, is expected to be completed some time during the first months of 1942. Mayor F. H. La Guardia officiated at the ceremony.



"Throughout the country, hospitals are awakening to the seriousness of the present situation and are giving major attention to it."—Modern Hospital

Dictaphone helps hospitals to maintain efficiency in National crisis

DICTAPHONE AIDS DEPLETED STAFFS TO FUNCTION NORMALLY

Many Dictaphone-equipped hospitals, large and small, have proved that this modern dictating machine saves valuable time and obviates the possibility of error in recording:

EXHAUSTIVE DIAGNOSES
ACCURATE CASE HISTORIES
PROMPT EXAMINATION FINDINGS
PRECISE X-RAY REPORTS
UP-TO-DATE CLINICAL RECORDS
COMPLETE AUTOPSY DATA

In these and many other routine and special matters, the Dictaphone Dictating Machine provides the easiest and most efficient method of getting things done.

The loss of many doctors, nurses, interns and technicians, who have answered the call to national defense, is presenting added burdens of work for those who remain. In maintaining normal hospital service in spite of depleted staffs, Dictaphone plays an important role.

Day and night, this modern dictating machine is always "on call" for immediate recording of essential data. Diagnoses, examination findings, reports of every nature can be taken down with Dictaphone *while facts are still fresh in mind!* A secretary's presence is not required —hastily-scrawled, easily-lost longhand notes are no longer needed.

Dictaphone enables all branches of hospital administration to get *twice as much* work done . . . quicker, more easily, more conveniently. Delays and serious errors are prevented because, for *on-the-spot* dictation, Dictaphone never goes "off duty!"

DICTAPHONE

The word DICTAPHONE is the Registered Trade-Mark of Dictaphone Corporation, Makers of Dictating Machines and Accessories to which said Trade-Mark is Applied.

Try a Dictaphone Dictating Machine in your hospital. There's no charge or obligation. Just mail the coupon.

Dictaphone Corporation, 420 Lexington Avenue, N. Y. C. MH-11-41
In Canada: Dictaphone Corporation, Ltd., 86 Richmond St., West, Toronto

☐ Please send me your folder, "Getting Things Done in Hospitals."

☐ I should like to see and try the new Dictaphone Cameo Dictating Machine without cost or obligation to me.

Name.....

Address.....

Hospital.....

Epidemic Diarrhea Causes 20 Infant Deaths; Conduct Hospital Investigations

WASHINGTON, D. C. — Outbreaks of epidemic diarrhea of the newborn at two Washington, D.C., hospitals, which caused the death of 20 infants since early August, have impelled the district committee of the House of Representatives to request an investigation and report from the local health department. The situation may bring about more stringent regulation of the hospitals of the city.

According to the health department's bureau of preventable diseases, 81 infants have been stricken by the disease since early in August. Of the 20 deaths, 8 were in one hospital and 11 were in another.

A constructive contribution to the situation has been made, according to Dr. Daniel L. Seckinger, assistant health officer, in the work of one of its employes on ensuring the sterility of formulas given to the newborn. It is believed that technics of preparing and handling the formula so that it contains a very low number of bacteria will prevent the disease.

The health department is cooperating with the hospitals in having formulas tested by its bacteriological laboratory and in seeing that prompt diagnosis and isolation procedures are carried out.

Michigan Blue Cross Plans Pay Hospitals on Cost Basis

Hospitals in Michigan are now being paid on a cost basis for their Blue Cross patients in accordance with a policy adopted by Michigan Hospital Service on July 1. This fact requires the hospitals to report their costs on a uniform accounting basis. The accounting system of the American Hospital Association is being followed.

In order to carry on the necessary work, Paul B. Soule, assistant executive secretary of the Cleveland Hospital Council since 1935, has been employed as auditor of the hospital department of the Michigan Hospital Service and began his duties on October 1.

While he was with the Cleveland Hospital Council, Mr. Soule developed a manual of hospital accounting for Cleveland hospitals; made studies of hospital ward costs, nursing costs and costs of maternity care; developed a formula for the allocation of community chest and county funds to participating hospitals, and served as secretary of various special committees of the council. Prior to his work with the council he was employed as a public accountant.

Direction of Medical Records School Reassumed by Founder

Mrs. Edna K. Huffman, R.R.L., organizer of St. Joseph Hospital's School for Medical Record Librarians, Chicago, the fourth school of this type to be approved, and more recently director of the Medical Records Librarians' School, Grant Hospital, Chicago, has reassumed the directorship of St. Joseph's School, which recently became affiliated with the college of liberal arts and sciences of DePaul University. Mrs. Huffman is the author of "Manual for Medical Record Librarians," which was published recently.

Alphild Anderson succeeds Mrs. Huffman as director at the Grant school, of which she is a graduate. Miss Anderson comes to Grant from Silver Cross Hospital, Joliet, Ill., where she was director of the medical records library.

Council to Study Health Agencies

Under a special grant of $75,000 from the Rockefeller Foundation, the National Health Council is undertaking a comprehensive study of the activities of all private health agencies in the United States, Dr. Kendall Emerson, president of the council, announces. Completion of the study is expected to take about three years.

Q. I've heard that some varieties of canned marine fish are good sources of vitamin D. Is that true?

A. Yes, it is. A four-ounce serving of canned salmon contains approximately 200 to 800 U.S.P. units of vitamin D-2. The body oils of sardines approach a good cod liver oil in vitamin A and D potencies. Therefore, canned sardines are another important dietary source of vitamin D. (1) It has been reliably estimated that the amount of canned salmon sold in this country alone contains more vitamin D than the cod liver oil used for both animal and human feeding. (2)

American Can Company, 230 Park Avenue, New York, N. Y.

---

(1) 1935. J. Home Econ. 27, 658.
(2) 1931. Ind. Eng. Chem. 23, 1066.

ACCEPTED AMERICAN MEDICAL ASSN.

The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

B. C. MacLean Studies Public Health During Sabbatical Year

An unusually dramatic indication of the public health implications of hospital work is the announcement that Dr. Basil C. MacLean, president of the American Hospital Association, has taken a sabbatical year to study public health at Johns Hopkins University.

Doctor MacLean is director of Strong Memorial Hospital of the University of Rochester, is a member of the administrative faculty of the school of medicine and dentistry of the university, a lecturer to senior medical students, a charter fellow and past president of the American College of Hospital Administrators, a member of the editorial board of The MODERN HOSPITAL, a member of the board of trustees and executive committee of the Rochester Hospital Service Corporation, a member of the board of the Rochester Council of Social Agencies, the Rochester Public Health Nursing Association and the Family Society of Rochester. He is a member of the Rochester Academy of Medicine and is medical director of the Maternal Consultation Center.

. His year of study at Baltimore is to be financed in part by a grant from the Commonwealth Fund. He took his medical degree at McGill University in 1927 and was assistant superintendent of Montreal General Hospital under Dr. A. K. Haywood from 1927 to 1930. He was superintendent of Touro Infirmary from 1930 to 1935, going to Strong Memorial in the latter year.

U.S.P.H.S. Names 88 Nursing Schools That Will Be Federally Aided

WASHINGTON, D. C. — Eighty-eight schools of nursing in 36 states have been named by the U. S. Public Health Service to participate in the federally aided program for increasing the number of student nurses in training. These schools will train about 2000 more students than in previous years. Sixty-seven schools in 32 states have been approved for aid in offering refresher courses to 3000 inactive registered nurses who want to return to duty. Twenty-six schools will enroll 500 graduate nurses for postgraduate study under the federal program.

A total of $1,200,000 in federal funds is available for the program, which includes also field training centers for public health nursing.

Although the student nurse training program will increase enrollment from 40,000 to only 42,000, and although Surgeon General Parran has estimated a need for 50,000 student nurses this year, the Public Health Service hopes that other schools will increase their enrollments without federal aid.

$105,000 to White Cross Hospital

Three legacies amounting to approximately $105,000 recently were presented to White Cross Hospital, Columbus, Ohio. One gift of $500 was received from Mrs. E. C. Beery of Athens, Ohio. Harvey A. Fry of Columbus, Ohio, willed the hospital $3000 and an interest in the residue of his estate, amounting to approximately $1500. The third gift came from Helen Thompson of Columbus, Ohio, and consists of the residue of her estate, approximately $100,000.

Moline Reduces Hospital Levy

Because of its proved ability to operate on its income, city officials have decided to reduce the hospital levy on Moline City Hospital, Moline, Ill., to less than $0.05 for each $100 valuation. The hospital's operating income for the last seven years, it was explained, has been sufficient to pay operating expenses and to assist in paying for expansion of the plant. Application has been made for a defense P.W.A. grant of $550,000 which, with $150,000 to be furnished by the city, will be used to replace the old wing of the hospital.

Hospitals and Red Cross Initiate O.C.D. Training Courses for Nurses' Aids

WASHINGTON, D. C. — One hundred and thirty-five hospitals and 46 local Red Cross chapters have already joined with the Office of Civilian Defense and the American Red Cross in initiating courses for training volunteer nurses' aids, Mrs. Walter Lippman, national director of the Volunteer Nurses' Aid Corps, said on October 16.

These institutions are located in 17 states. Many additional Red Cross chapters and hospitals have indicated their interest in the program, which was announced by Mayor F. H. La Guardia, director of the Office of Civilian Defense, late in August, and are expected to begin their courses soon.

A manual on medical care and nursing for the use of agencies cooperating in the volunteer program is now being prepared under the direction of Marian G. Randall, recently appointed nursing consultant in the medical division of the Office of Civilian Defense.

Six designs for uniforms for volunteer workers, including nurses' aids, have just been approved by the Office of Civilian Defense. Upon completion of their training, nurses' aids will be awarded uniforms consisting of light blue dresses, white caps and a triangular red cross emblem on the left sleeve. This uniform, unlike those to be used by volunteer office, canteen and hospital workers and by auxiliary policewomen and air raid wardens, will be sold to no one and will be issued only upon completion of the training course.

Chicago Health Needs Outlined

A blueprint of the unmet health needs of Chicago and the steps that should be taken was published last month by the health division of the Council of Social Agencies. First on the list is more hospital and clinic services and sanatorium beds for Negroes. City and county expenditures for hospital and clinic care, tuberculosis sanatorium services and care for the chronically ill should be increased, the program states. Provision for nearly 2,000,000 additional clinic visits annually should be provided. There is a general inadequacy of free hospital beds and of beds in tuberculosis, chronic disease and convalescent hospitals.

Grace Hospital Receives Bequest

A bequest of $50,000 has been granted Grace Hospital, New Haven, Conn., by Carrie Silverthau.

St. Vincent's Annual Report Issued

An unusual annual report was published recently by St. Vincent's Hospital, New York City. The booklet is made up of progressive folds, each covering a specific division, the contents of which are boldly labeled on outside tabs. Graphic presentations add to the booklet's interest and its compact form and bright blue cover give it attraction value.

Dr. Eugene F. DuBois Honored

More than 250 physicians from eastern states gathered at the Waldorf-Astoria, New York City, on October 9 for a dinner honoring Dr. Eugene F. DuBois upon his retirement as physician-in-chief of the New York Hospital and professor of medicine at Cornell Medical College. Doctor DuBois is well known for his work on metabolism. In addition, he has directed many studies on medical problems connected with national defense.

Wesley Seeks Fund for Furnishings

According to F. J. Thielbar, president of the board of trustees for Chicago's new 20 story, $3,200,000 Wesley Hospital, a campaign to raise $400,000 for furnishings and equipment has been initiated.

Hospitals to Take Part in Proposed Rehabilitation of Rejected Selectees

WASHINGTON, D. C.—Hospital priorities and plans for the rehabilitation of selectees rejected for Army service because of physical disabilities were the most important topics discussed at a meeting October 2 and 3 of the subcommittee on hospitals of the Health and Medical Committee (now an advisory body of the Defense Health and Welfare Services in the Office for Emergency Management), according to Dr. Winford H. Smith, chairman.

On the second day of the subcommittee meeting, the members conferred with the selective service staff concerning the rôle of hospitals in physical rehabilitation plans now in the making. It is understood that local hospitals and clinics and civilian physicians and dentists will be employed.

President Roosevelt announced on October 10 that the rehabilitation of 200,000 registrants who have been rejected for disabilities believed to be readily remediable would be undertaken immediately. A report submitted to the president by Gen. Lewis B. Hershey, director of selective service, showed rejections for these causes: 20.9 per cent, dental defects; 13.7 per cent, defective eyes; 10.6 per cent, cardiovascular diseases; 6.8 per cent, musculo-skeletal defects; 6.3 per cent, venereal diseases; 6.3 per cent, mental and nervous diseases; 6.2 per cent, hernia; 4.6 per cent, defects of ears; 4 per cent, defects of feet, and 2.9 per cent, defective lungs, including tuberculosis. Miscellaneous physical conditions accounted for the remaining 17.7 per cent.

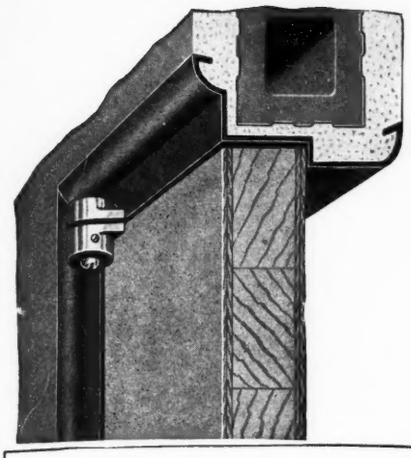
The president explained to his press conference that most of the dental cases can be fully rehabilitated. Most venereal disease cases will also be easily rehabilitated and the men affected made fit for Army service. Among the cardiac cases, rehabilitation of a substantial proportion will not be attempted. About one quarter of the hernia cases can be corrected, the president estimated, but relatively few rehabilitations may be achieved among the mental cases or those suffering from ear, feet or lung defects.

The Army up to July 1 had been rejecting more than 40 per cent of the men examined and has definitely decided to maintain its present high physical standards of eligibility, rejecting the proposal that it should itself undertake a rehabilitation program after induction of physically handicapped selectees. It is assumed that the percentage of rejections will decline somewhat now that men from 28 to 36 are omitted from the examination lists.

The voluntary rehabilitation program was recommended by a commission on physical rehabilitation of which Dr. George Baehr, Columbia University, is chairman. Other members of the commission are: Dr. Arthur W. Allen, Massachusetts General Hospital, Boston; Dr. Frederic A. Besley, Northwestern University Medical School, Chicago; Dr. Channing Frothingham, Faulkner Hospital, Jamaica Plain, Mass.; Dr. Harry S. Gradle, Illinois Eye and Ear Infirmary, Chicago; Dr. John J. O'Rourke, dean of the Dental School, Louisville, Ky., and Dr. Malcolm T. MacEachern, American College of Surgeons.

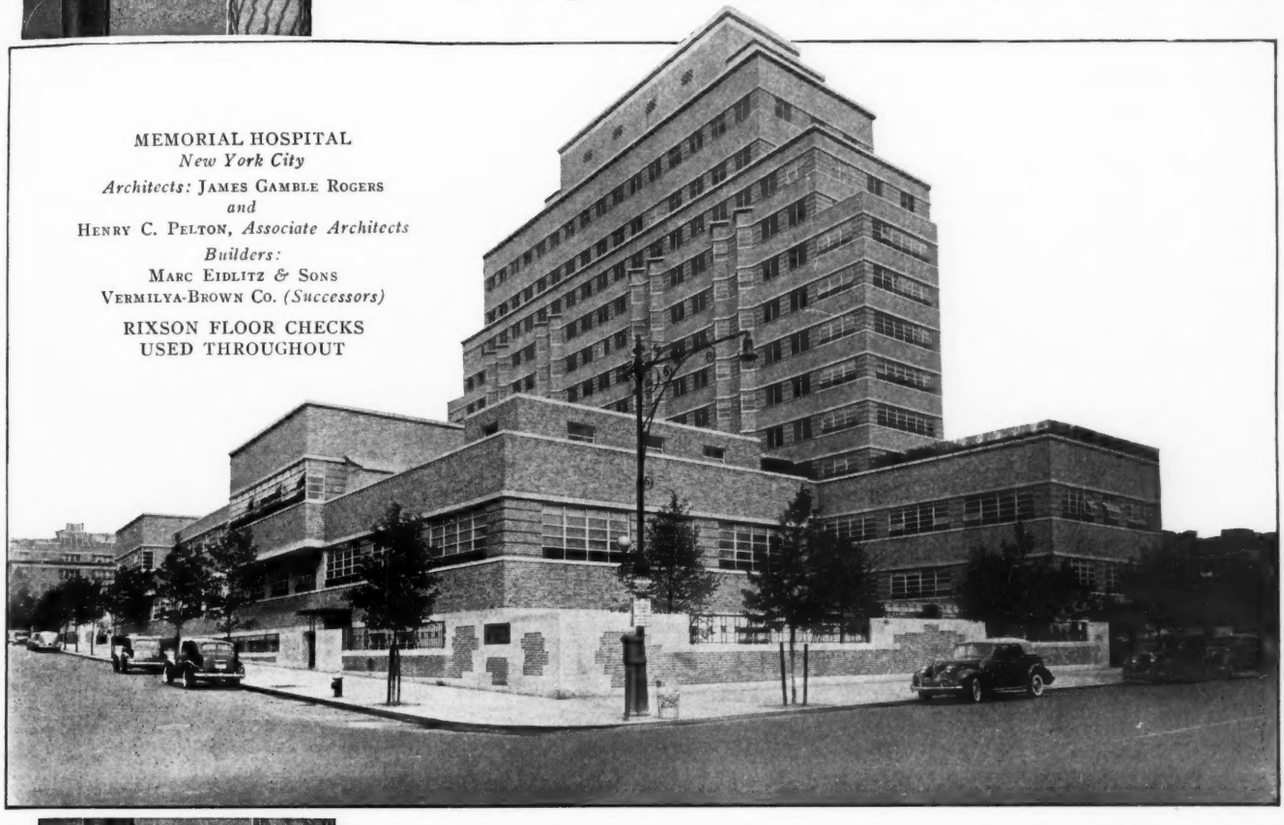
Employes Eligible for Insurance

One hundred and twenty-two employes of Ohio Valley Hospital, Steubenville, Ohio, are now eligible to life insurance protection in amounts ranging from $500 to $1000 each, according to salary received. The policy was issued by one of the large insurance companies and involves a total of $72,000. Both employes and the hospital will share in the payment of the premiums, the policy having been issued on a contributory basis.

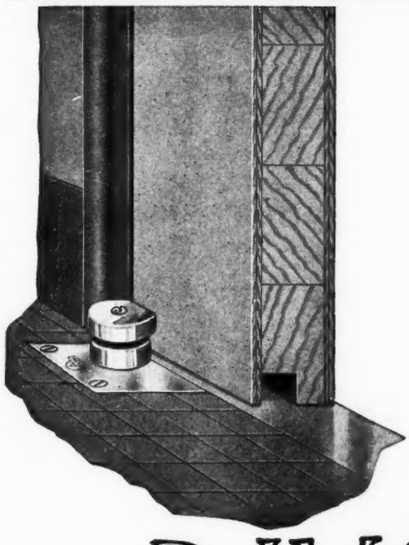


WHAT Well-Tailored Doors ARE WEARING THIS YEAR

● To give doors that "tailored", clean-cut appearance—not as a matter of fashion, but of clean-cut *functional design*—That's how architects are arriving at **RIXSON Uni-Check** as the standard closing mechanism for single-acting interior doors in hospitals.



MEMORIAL HOSPITAL
New York City
Architects: JAMES GAMBLE ROGERS
and
HENRY C. PELTON, *Associate Architects*
Builders:
MARC EIDLITZ & SONS
VERMILYA-BROWN CO. *(Successors)*
RIXSON FLOOR CHECKS
USED THROUGHOUT



The absence of protruding arms, hangers, housings—in fact, anything to break the clean sweep of walls and doors—is a relief to the eye. But, functionally, the **Uni-Check,** at a cost that competes with any other type of check, provides automatic quiet closing—eliminates hard-to-clean or dust catching surfaces—offers no obstruction to mops, dust cloths or paint brush . . . All good features for the hospital.

RIXSON Uni-Checks not only are ideal for hospital use but are excellent wherever self-closing interior doors are a convenience or necessity. Full information available on request. Complete catalog information is on file with most architects. SPECIFY RIXSON UNI-CHECK FOR ALL INTERIOR SINGLE ACTING DOORS THAT HAVE TO BE SELF-CLOSING.

THE OSCAR C. RIXSON CO., 4454 Carroll Ave., Chicago, Ill.

RIXSON REPRESENTATIVES AT:

New York: 2034 Webster Ave - Philadelphia: 211 Greenwood Avenue, Wyncote, Pa. - Atlanta: 152 Nassau Street - New Orleans: 2630 Jefferson Ave. - San Francisco: 116 New Montgomery Street - Seattle: 4012 E. 38th Street - Los Angeles: 909 Santa Fe Avenue - London, Ontario, Canada: Richards-Wilcox, Ltd.

RIXSON *Uni-Check*

Hospital Facilities Reports Issued

Detailed reports for seven states on hospital facilities in 1939 had been made public by the U.S. Bureau of the Census by the middle of October. The states covered are Alabama, Arizona, Arkansas, California, Colorado, Connecticut and Delaware. A preliminary summary reviewed in the October issue of The Modern Hospital is also available.

Each report contains maps showing the distribution of hospitals, sanatoriums, nursing, convalescent and rest homes and other institutions. Each report contains information in tables and text on the distribution of institutions by population, by type of institution, by control and by registration or approval.

Tuberculosis Hospital for Houston

Houston voters at a municipal bond election on October 4 approved an expenditure of $650,000 for a tuberculosis hospital. Present facilities provide 170 beds for treatment of both children and adults and tentative plans for the proposed hospital will add approximately 300 beds to this total. The new structure, according to plans based on funds from the municipal bonds only, will be eight stories high, situated in an uncongested area and fully serviced with the most modern equipment.

Now Uses Disposable Dishes

Los Angeles County General Hospital, the world's largest general hospital, started using disposable dishes on October 1. Bowls, plates, sauce dishes and cups are of especially designed paper and fiber and are burned immediately after using. Since an average of 30,000 pieces is used daily, the dishes have considerable fuel value.

Faced with a serious dishwasher shortage because of defense industry jobs available, administration authorities at General Hospital began experimenting with the paper tableware. A complete change-over soon followed and some 60 kitchen helpers were released or transferred to much needed ward duty. Whereas several kitchens were needed formerly throughout the vast ward areas, one kitchen now suffices. From there, trains of carts carrying food and paper dishes are hauled by electric tram to the wards.

While the labor problem was a factor in the radical change to paper dishes, monitors in the county hospital assert that economy and sanitation were also vital. The new dishes are extremely lightweight for both patient and employe, yet strong and resistant to grease and liquids. Too, no time is required for dish scraping, washing and sterilizing.

Cost of the fiber dishes, when purchased in the quantities necessary to feed 3000 patients thrice daily, is estimated at less than 2 cents per meal.

Name Faculty for Texas Institute

Dr. Arthur C. Bachmeyer, Ada Belle McCleery, Dr. Malcolm T. MacEachern and James A. Hamilton constitute the faculty that will conduct the first Texas Hospital Institute to be held at Southern Methodist University, Dallas, from November 17 to 28. This institute will follow closely the pattern of the Colorado Institute held during the summer with a small faculty, close personal relationships between faculty and students and relatively few evening sessions. Albert Seawell of City and County Hospital, Fort Worth, is secretary.

Warren City Plans Building Program

Warren City Hospital, Warren, Ohio, has completed a campaign to raise $300,000 for expanding the present hospital facilities. A 40 foot addition to the west wing of the hospital is being built now and will be completed December 1. This will add 30 beds and bring the total bed capacity to 186. Plans have been completed for a new east wing which will be started next spring.

WYANDOTTE DETERGENT SAVES YOU MONEY

In your building, tile, marble, porcelain, and painted surfaces all need periodic cleaning.

Think of the advantages that one cleaning-agent—Wyandotte Detergent—offers you for *any* cleaning purpose. . . . First of all, because it is an all-around cleaner — the only one you need in the building — you can buy in large lots and save money. In addition, it is quick-acting and free-rinsing — you save on labor costs. Because Wyandotte leaves no film, *surfaces actually stay clean longer!*

More and more building superintendents are standardizing on Wyandotte Detergent for *all* their maintenance cleaning.

Your Wyandotte Service Representative can show you how to get the most out of Wyandotte Detergent. Why not call him today?

Wyandotte
PRODUCTS
SERVICE REPRESENTATIVES IN 88 CITIES

THE J. B. FORD SALES COMPANY • WYANDOTTE, MICHIGAN

California Doctors Stop Full Coverage Contracts for Women

Owing to adverse experience from various groups, the California Physicians' Service on October 1 raised its dues for women subscribers and called a halt to sales of its full coverage contracts. From now on sale of the contracts that do not cover the first two physician's visits will be pushed in place of the full coverage contracts. The secretary was authorized to cancel or modify existing contracts when there is evidence that the subscribers have abused the privileges.

The executive committee of the organizations was authorized to develop methods of including the dependents of wage earners under the limited surgical plan contract. In the future emphasis will be placed on the limited surgical contract for all groups.

These changes were said to be due to the fact that 17 per cent of the subscribers were calling for service each month and that the average usage was one unit of service per dues-paying member per month. Most of the service is reported to be for the dependents' minor illnesses. Fifty-six per cent of the subscribers are women, it is stated, and they use 75 per cent of the service.

The association also concluded that too high a percentage of its participants is from the white collar classes.

Coming Meetings

Nov. 3-6—Hospital Standardization Conference, American College of Surgeons, Statler and Copley-Plaza hotels, Boston.
Nov. 3-7—American Association of Medical Record Librarians, Hotel Westminster, Boston.
Nov. 6—Nebraska Hospital Assembly, Yancey Hotel, Grand Island, Neb.
Nov. 8-9—Association of California Hospitals, Hotel Californian, Fresno, Calif.
Nov. 10—Association of Western Hospitals, Public Hospitals Section, Fresno, Calif.
Nov. 12-13—Kansas Hospital Association, Topeka.
Nov. 13—Colorado Hospital Association, Cosmopolitan Hotel, Denver.
Nov. 13-14—Oklahoma Hospital Association, Tulsa.
Nov. 17-28—Southwestern Institute for Hospital Administrators, Southern Methodist University, Dallas, Tex.
Dec. 4—Utah Hospital Association, Salt Lake City.
Feb. 26-28—Texas Hospital Association, Houston.
March 7-9—New Jersey Hospital Association, Hotel Dennis, Atlantic City.
March 11-13—New England Hospital Assembly, Hotel Statler, Boston.
March 20—Louisiana Hospital Association, Washington Youree Hotel, Shreveport.
April 6-10—American Congress on Obstetrics and Gynecology, St. Louis.
April 9-11—Southeastern Hospital Conference, Peabody Hotel, Memphis, Tenn.
April 9-11—Georgia Hospital Association, Peabody Hotel, Memphis, Tenn.
April 13-16—Association of Western Hospitals, Olympic Hotel, Seattle, Wash.
April 15-17—Pennsylvania Hospital Association, William Penn Hotel, Pittsburgh.
April 21-23—Ohio Hospital Association, Neil House, Columbus.
April 23-24—Mid-West Hospital Association, Hotel Continental, Kansas City, Mo.
April 27-29—Iowa Hospital Association, Fort Des Moines Hotel, Des Moines, Iowa.
May 11—Mississippi State Hospital Association, Jackson.
May 17-22—American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Biennial Convention, Stevens Hotel, Chicago.
May 20-22—Hospital Association of New York, Hotel Statler, Buffalo.
May 22—Greater New York Hospital Association, New York City.
June 8-12—American Medical Association, Atlantic City, N. J.

Blue Cross Day Opened With Goldwater's Radio Address

A nationwide radio broadcast by Dr. S. S. Goldwater over the Mutual network and local observances in all of the headquarters cities of the 67 approved hospital service plans marked Blue Cross Day on October 28.

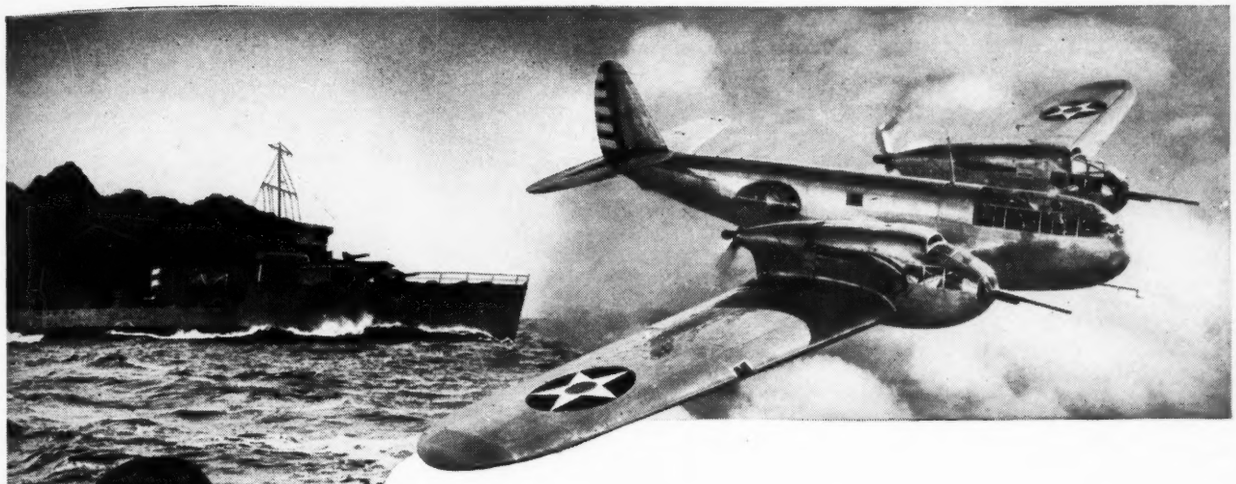
On this day the various approved plans had paid hospital bills for their participants totaling $100,000,000 and had reached a total enrollment of 7,500,000 persons, of whom 2,000,000 had received hospitalization. Some 250,000 babies had been born "under the sign of the Blue Cross," which, according to the plans, is more auspicious than any of the signs of the zodiac.

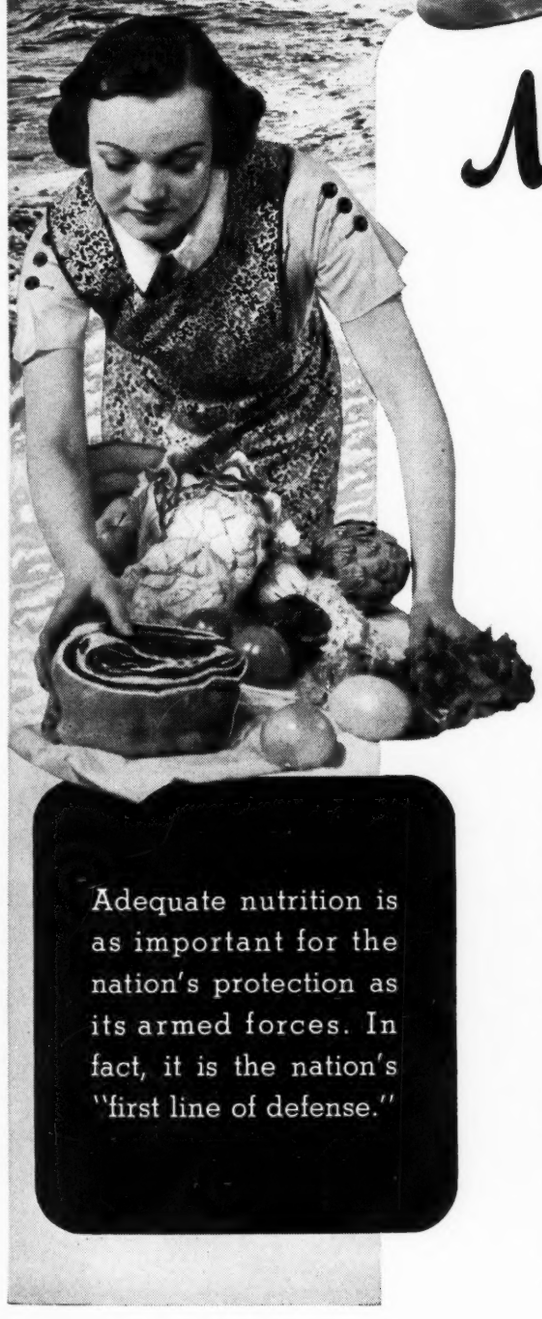
Grant Opens Rehabilitation Clinic

Returning handicapped men and women to jobs will be done in Chicago at Grant Hospital's new rehabilitation clinic. By means of plastic surgery, the clinic will attempt minimization of original or acquired disfigurements and disabilities that prove mental or physical liabilities to job seekers.

Three Injured in Laboratory Fire

A student nurse and two laboratory technicians were burned on October 20 in an explosion and fire in the laboratory of the American Hospital, Chicago.





Adequate nutrition is as important for the nation's protection as its armed forces. In fact, it is the nation's "first line of defense."

Meat...

and Its Place Among the "Protective Foods"

WHEN the term "protective foods" was first coined it was applied almost exclusively to citrus fruits, green leafy vegetables, and dairy products, then known to be rich in vitamins or minerals or both. Many foods, unconsidered in the early days of vitamin studies, have since been shown to be remarkably rich in vitamins and minerals, and therefore in reality rank high among "protective foods." Meat, particularly, deserves this distinction.

Meat and meat products are important natural sources of thiamine, riboflavin, nicotinic acid and probably other components of the B complex. Because of its great palatability, meat is universally liked and can be eaten in ample amounts daily, to supply a goodly portion of the daily vitamin requirements.

In addition, meat is one of the richest sources of biologically adequate proteins. It also provides important amounts of the essential minerals iron, copper, and phosphorus.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

CHICAGO

Names in the News

Administrators

ERNA A. BERGEMAN, Mankato, Minn., has been named superintendent of the Edgerton Memorial Hospital, Edgerton, Wis.

CATHERINE M. GEIMAN assumed her new duties as superintendent of Seidle Memorial Hospital, Mechanicsburg, Pa., on September 30, succeeding ELIZABETH M. MYERS, who resigned after having served as superintendent of the hospital since its establishment four years ago.

HELEN R. SAUNDERS, R.N., formerly superintendent of Harbor View Hospital, Sydney Mines, N. S., became superintendent of James Hamet Dunn Hospital, Bathurst, N. B., September 22.

SUZANNE M. FREEMAN, superintendent of Worcester Hahnemann Hospital, Worcester, Mass., since 1913, has announced her resignation to take effect as soon as her successor is appointed.

DR. H. P. LEE, assistant physician at Toledo State Hospital, Toledo, Ohio, for the last twelve years, has been appointed superintendent of Cleveland State Hospital, Cleveland. Doctor Lee will fill the post left vacant by DR. R. E. BUSHONG, who has been named state commissioner of mental diseases.

ROBERT E. NEFF has been named administrator of the Psychopathic Hospital, Iowa City, Iowa, in addition to his duties as administrator of the General Hospital. Pending the appointment of a permanent medical director of that hospital and a head of the University of Iowa's department of psychiatry, DR. WILBUR R. MILLER will serve as acting medical director and head of the department.

DR. LEWIS BARBATE assumed his new duties as superintendent of San Antonio State Hospital, San Antonio, Tex., recently. Doctor Barbate formerly was assistant superintendent of the state psychiatric hospital in Galveston, Tex. He succeeds DR. W. J. JOHNSON as head of the San Antonio institution.

BERTHA E. BEECHER has resigned as assistant to the superintendent of Christ Hospital, Cincinnati. Miss Beecher will continue as superintendent of the deaconess work connected with the Elizabeth Gamble Deaconess Home Association.

SISTER ALPHONSINE, formerly superintendent of De Paul Hospital, St. Louis, has been transferred to St. Vincent's Hospital, Los Angeles.

DR. JOSEPH S. DRABANSKI has been appointed managing officer of Chicago State Hospital, Dunning, Ill., to succeed DR. EDWARD F. DOMBROWSKI.

GUY M. HANNER, administrator of Beth-El General Hospital, Colorado Springs, Colo., for more than twenty years, assumed his new duties as administrator of the Desert Sanatorium of Southern Arizona, Tucson, Ariz., on October 1.

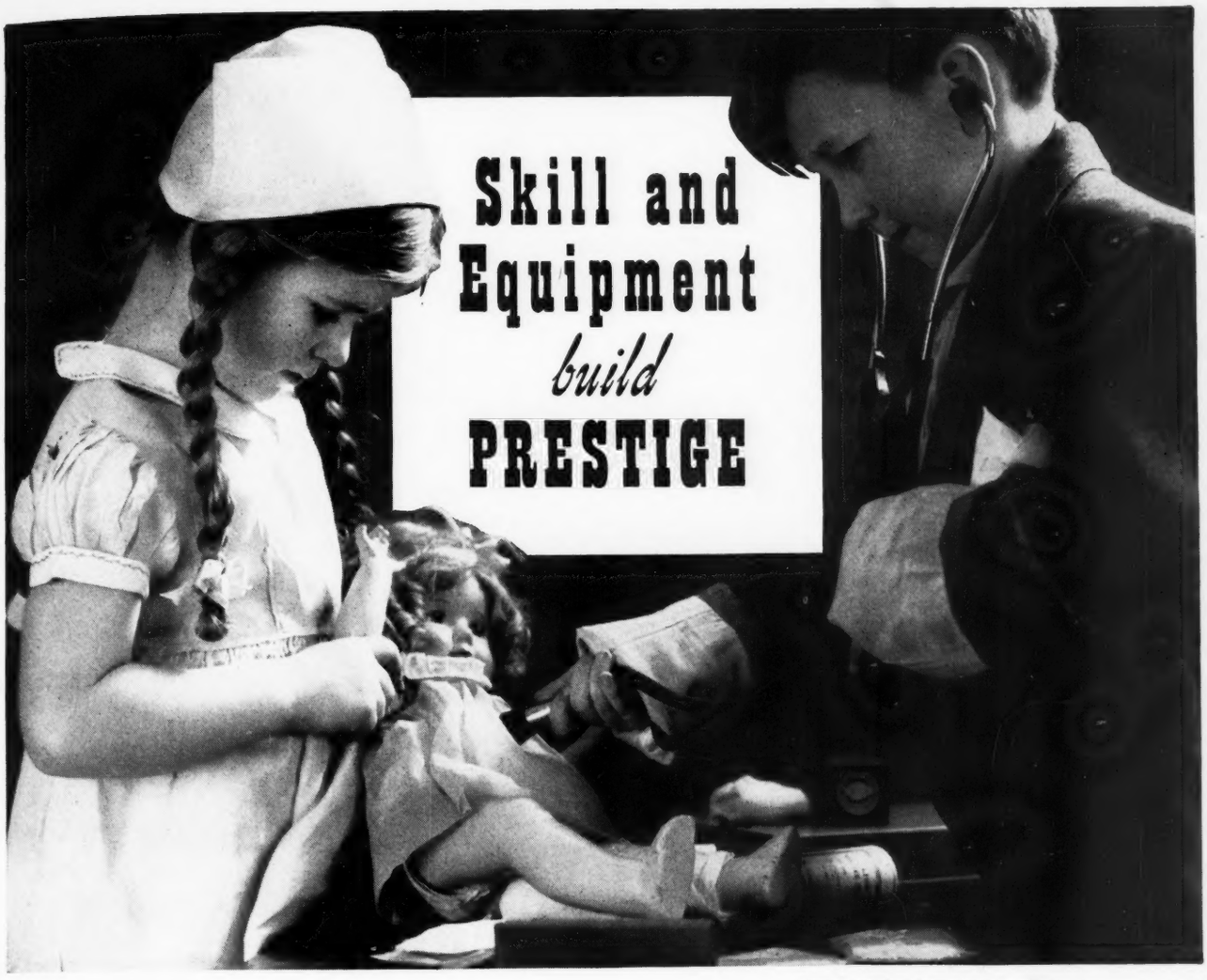
JEANETTE TAYLOR, for the last three years superintendent of Union Hospital, Dover, Ohio, resigned her position, effective November 1.

ROBERT W. BACHMEYER became assistant to the director of Hospital for Special Surgery, New York City, on September 22. Mr. Bachmeyer formerly served as administrative intern at St. Luke's Hospital, New York City.

ROLAND A. SCOTT has been appointed administrator of the Burnham City Hospital, Champaign, Ill., effective October 1. For the past year he has been associated with the Evangelical Hospital of Chicago as assistant superintendent.

EDITH MARDEN, superintendent of Waltham Hospital, Waltham, Mass., for the last twenty years, has tendered her resignation to become effective November 1. Miss Marden plans to retire from active hospital service.

MELVIN L. SUTLEY has been appointed administrator of Wills Hospital, Philadelphia, succeeding STEPHEN WIERZBICKI,



Your sincere effort to make your hospital outstanding in its community calls for two factors—a skilled staff and adequate equipment. Both play important parts in creating faith in your service and prestige for your institution.

THE HEIDBRINK KINET-O-METER is the preferred anesthesia equipment in many leading hospitals that realize the extreme importance of this type of apparatus.

The Kinet-o-meter is preferred because of its simple, understandable, economical operation.

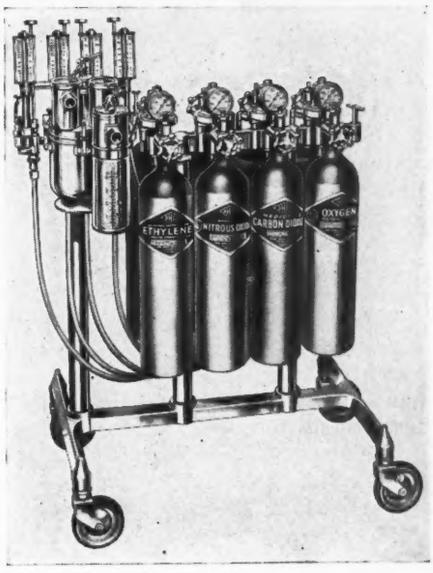
The Kinet-o-meter is preferred because of its sturdy construction and its flexibility of adjustment where the operating table must be tilted to extreme angles.

The Kinet-o-meter is preferred because it gives both the doctor and the anesthetist the anesthesia equipment which meets their requirements and which is adequate for any emergency.

The Kinet-o-meter is preferred because each gas is controlled and delivered independently and may be administered separately or in combination with any one or all of the other gases.

The Kinet-o-meter is preferred because it has a wide range of usefulness.

The Kinet-o-meter brochure describes in detail the 4-gas, the 3-gas and 2-gas Heidbrink anesthesia apparatus and accessories. Mail the coupon for a copy.



OHIO

THE OHIO CHEMICAL & MFG. CO.

Pioneers and Specialists in Anesthetics

1177 MARQUETTE STREET, CLEVELAND, OHIO

Branches in all Principal Cities

THE OHIO CHEMICAL & MFG. CO., CLEVELAND, OHIO

Please send your brochure giving complete details and specifications of the Kinet-o-meter.

Name _____

Address _____

City _____ *State* _____

who died in August. For the last fourteen years Mr. Sutley has been superintendent of Delaware County Hospital, Drexel Hill, Pa.

Dr. John B. Cipriani has been named managing officer of Illinois Eye and Ear Infirmary, Chicago, succeeding Dr. S. W. Parowski.

Donald Wair, formerly acting head of Eastern Oregon State Hospital, Pendleton, Ore., has been named permanent superintendent of that institution.

Morrell Goldberg, assistant superintendent of Beth El Hospital, Brooklyn, N. Y., has been appointed superintendent of the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N. Y.

Department Heads

Ohle Gill, after eighteen years' association with White Plains Hospital, White Plains, N. Y., resigned her position as superintendent of nurses on September 13. Miss Gill has been succeeded by Marian Thuma, a graduate of Johns Hopkins Hospital School of Nursing.

Stella Heinze, formerly executive housekeeper at St. Barnabas Hospital, Minneapolis, Minn., assumed the duties of executive housekeeper at the University of Illinois Research Hospital, Chicago, on September 1.

Eleanor Crowe has been appointed medical social service director of White Plains Hospital, White Plains, N. Y., succeeding Ruth Wonacott, who established the department of medical social service in January 1940 and who resigned in September to direct the government medical social work in Puerto Rico.

Miscellaneous

George Fishback has succeeded Ralph W. Jordan as executive secretary of the Ohio Hospital Association, Columbus.

Henrietta Landau resigned August 23 as consultant public health nurse in the Division of Public Health Nursing, Albany, N. Y., to accept a position with the U. S. Public Health Service with headquarters in Chicago. In her new position, Miss Landau acts as consultant nurse in six midwestern and southern states.

Mary E. Parker has been appointed consultant nurse in the Bureau of Cardiac Diseases, New York State Department of Health.

Dorothy Deming, R.N., general director of the National Organization for Public Health Nursing, has resigned, effective November 1. Miss Deming is a former editor of *Public Health Nursing*.

Rev. Russell L. Dicks has resigned his position at Presbyterian Hospital, Chicago, to serve as associate pastor at Highland Park Methodist Church, Dallas, Tex., and as assistant professor of pastoral work in the School of Theology at Southern Methodist University. Mr. Dicks is the author of a religious manual for nurses, "Who Is My Patient?" which was published last month. He also collaborated with Richard Cabot in writing "The Art of Ministering to the Sick."

Deaths

Dr. Dean DeWitt Lewis, professor emeritus of surgery at Johns Hopkins Medical School and former surgeon in chief of Johns Hopkins Hospital, died on October 9.

Dr. Edward B. Lane, first superintendent of Boston State Hospital, Boston, died on September 17 at the age of 81.

Mrs. W. N. Vaughn, former superintendent of Waynesboro Community Hospital, Waynesboro, Va., died at Goldsboro, N. C., following a short illness.

Sister Mary Mercy Giblin, R.S.M., former supervisor of pediatrics at Mercy Hospital, Chicago, died October 16 in the hospital after an illness of several months.

L. D. Fowler, executive vice president of the Hospital Care Corporation, Cincinnati, died on October 19 following an operation for appendicitis. Mr. Fowler came to the plan from the insurance business in January 1940. Maurice E. Pollak, leading Cincinnati industrialist, is president of the plan.

Books on Review

THE BAKER MEMORIAL. *A Study of the First Ten Years of a Unit for People of Moderate Means at the Massachusetts General Hospital. By Haven Emerson, M.D. New York: The Commonwealth Fund,* 1941. *Pp.* 75.

The Baker Memorial unit of the Massachusetts General Hospital, Boston, received its first patient on March 3, 1930; during the intervening decade it has served an increasingly large number of patients of moderate means, has won a substantial place for itself in the affections of the physicians and patients in the Boston area and has progressed from a substantial liability on the books of the hospital to an economically self-supporting (although not self-liquidating) unit.

Doctor Emerson's review of the history of this unit well justifies the faith which Doctor Washburn had in it as early as 1910 when he first began work on his trustees and contributors to make this aid available to those who are neither rich nor poor.

However, Doctor Emerson sets up essential criteria for the operation of a middle-rate plan on such a grand scale that it can be made available only in the large teaching centers in which a building fund of $1,000,000 to $2,000,000 can be raised. Even then, he predicts a substantial operating deficit for the first few years.

The book is excellently written and will make interesting—even if not exciting—reading for hospital administrators and trustees.—ALDEN B. MILLS.

MANUAL FOR MEDICAL RECORDS LIBRARIANS, *By Edna K. Huffman, R.R.L. Chicago: Physicians' Record Co.* 1941. *Pp.* 308.

This new manual fills a great need in the hospital field, especially for the medical records librarian. It deals with the everyday problems of the medical records department in a simple, practical manner. The author has spared no pains in her exhaustive research and from her own experience brings us a book full of authoritative, interesting material.

The book is divided into four sections:

Section 1 deals with the history and content of the medical record, its value and those responsible for its compilation. It defines various laboratory tests and reparative materials used in surgical technic. Chapter V on nurses' notes should be especially useful to the nursing profession in making these notes a valuable part of the medical record.

In section 2 the author covers the procedures in the medical records department, its organization, management, methods of filing, practical information on nomenclatures and cross-indexing of diseases and operations, storage problems and how to overcome them, statistics and the compilation of monthly and annual reports.

The qualifications and training of the medical records librarian are explained in section 3. The chapter on medical terminology is of great value as it defines medical terms by means of stems, suffixes and prefixes. Medical abbreviations and hospital terms are also defined. Another chapter on jurisprudence is especially enlightening and may well be used as a guide in the medico-legal aspects of medical records.

Section 4 deals with the secondary duties of the medical records librarian. It shows how the medical reference and medical records libraries may be correlated.

To all those interested in medical records this book is of inestimable value. —ALICE G. KIRKLAND.